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MARYLAND STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

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Maryland State Medical Journal

THE MARYLAND STATE MEDICAL JOURNAL

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Medical and Chirurgical Faculty of the State of Maryland

VOLUME 3

January, 1954

NUMBER 1

PRESIDENTIAL EDITORIAL¹

THE GENERAL PRACTITIONER—SPECIALIST TEAM

BENDER B. KNEISLEY, M.D.²



BENDER B. KNEISLEY, M.D.

It is agreed, without exception, by medical men, that the true reason for the practice of their profession is to serve the best interests of the patient. Fundamentally, all other interests, although of some importance, should be secondary.

¹ Editor's note: Dr. Kneisley is a General Practitioner.

² President, Medical and Chirurgical Faculty, 1954.

In Hagerstown, Maryland, with a population of forty thousand people, the general practitioner (forty percent) and men in the specialty fields (sixty percent) have long enjoyed a very helpful and pleasant relationship. There is a feeling of mutual respect. Clinical pathological conferences are attended by both general and specialty men, and both actively participate in the meetings. Consultations occur regularly and their number is probably what might be considered average for such a community. In short, the general practitioner-specialist team works well in a small city of forty thousand people.

With the rapid advancement and change in medical problems, both as to diagnosis as well as treatment, the patient will need help from many medical sources in order that the wide spectrum of medical knowledge may be brought to bear on his disease. It is therefore logical and sound that the general practitioner and specialist in many instances operate as a team if the patient is to get the full benefit of present day medicine. The word *team* is emphasized because of its very meaning. Of course, much can be, and is being accomplished by each doctor going his own way, a sort of every man for himself attitude. But if this attitude becomes too general or too frequently practiced, the patient's interest may suffer or even be in jeopardy. Obviously, a general practitioner, able as he may be, should not continue to assume the responsibility of a seriously ill patient whose affliction is undiagnosed. And even if the diagnosis is made, and be correct, consultation is in order in many cases. One feels that most family doctors will and do ask for consultations. Surely it is for the best interest of the patient, and at the same time the family physician gathers valuable information.

The general practitioner-specialist team at work can be a most pleasant experience as well as rewarding to all participants. Such a team will not have the star player philosophy but will cooperate to give the best efforts to win the game—for the patient.

Osler, in his presidential address to the Medical and Chirurgical Faculty on April 27th, 1897, among other good thoughts, had this to say:—

"No class of men needs friction so much as physicians; no class gets less. The daily round of a busy practitioner tends to develop an egoism of a most intense kind, to which there is no antidote. The few set backs are forgotten, the mistakes are often buried, and ten years of successful work tend to make a man touchy, dogmatic, intolerant of correction and abominably self-centered. To this mental attitude the Medical Society is the best corrective, and a man misses a good part of his education who does not get knocked about a bit by his colleagues in discussions and criticisms." . . .³

If medicine is to have its best chance for the patient, doctors will have to keep abreast in a period of fast paces, and in many instances, they will have to operate mutually, with consideration and understanding of the problems of each.

³ Cushing, Harvey, *The Life of Sir William Osler*, Vol. I, Page 447, 1925.

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PLEASE ANSWER THE QUESTIONNAIRE

From the Council on Medical Education and Hospitals of the A.M.A.

—THIS IS OUR OBLIGATION—

Keeping up-to-date in medicine is essential for the physician who is endeavoring to render good medical care to his patients. In order to aid those who are charged with the responsibility of helping you in this phase of your professional life, the Council on Medical Education and Hospitals is presently making an intensive nationwide study of the problems in this field. The medical schools, medical societies, and other organizations engaged in postgraduate and other programs have been canvassed for their ideas.

To balance this picture, the views of the practicing physician must be obtained. The ultimate benefit of this study should be an extension and improvement of the ways and means that you and your colleagues have found most effective in keeping up-to-date.

It is urged that a questionnaire being sent to you by the A.M.A. Council on Medical Education and Hospitals be completed and promptly returned. It is to your interest to do so!

MRS. HOBBY URGES MORE STATE MONEY BE USED IN REHABILITATION

The AMA Washington Letter, No. 44

The time has come to reverse the trend and use more state and less federal money in vocational rehabilitation work, in the opinion of Secretary Hobby. Addressing the National Rehabilitation Conference, the Secretary of Health, Education, and Welfare noted that in 1921 when the program started the federal share was only one-third. (However, this was for only a part of a year.) Federal contributions reached a peak of 73.5% in 1947, and have declined to about two-thirds for the current fiscal year. Mrs. Hobby remarked that appropriations committees in Congress already have begun to "question the wisdom of providing such a proportion of federal funds for a program keyed to the principle of state operations. . . . To me it is simply additional evidence that the time has come to review and inventory our programs."

Without further elaboration, Mrs. Hobby said that her department "plans to propose legislation to strengthen administration of the program and to permit new approaches to old problems, without disrupting the important work which the state agencies are carrying on daily."

The Secretary indicated she thought the Manion Commission would look into such programs as vocational rehabilitation. She said the commission, currently studying U. S.-state relations, "offers a promise for a healthy re-examination of federal, state and local governmental interrelations, and I think we must all welcome their efforts to clarify the roles of each."

Maryland Academy of General Practice

Executive Secretary—Mr. William J. Wiscott, 1818 Ashburton Street, Baltimore



MERRILL M. CROSS, M.D.,
President-elect



LAURISTON L. KEOWN, M.D.,
President

NEW OFFICERS

At the Annual Meeting in the Lord Baltimore Hotel, October 20, 1953, the following officers were elected for 1954:

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"GENERAL PRACTITIONER OF THE YEAR"

Dr. Bender B. Kneisley of Hagerstown was named "General Practitioner of the Year" by his fellow members of the Maryland Academy at the Lord Baltimore Hotel, October 21, 1953.

Nomination of Dr. Kneisley as the State's outstanding family doctor came at the banquet which culminated the all-day scientific session of the Academy, attended by some 300 doctors.

Dr. Louis Krause, who presented a bronze plaque award, cited Dr. Kneisley for his exemplary work as both physician and citizen and his untiring efforts in behalf of improved medical services to the State.

Dr. Kneisley was one of the original organizers of the Maryland Academy, and has served on important committees and was elected Vice President.

LADIES AUXILIARY

At the invitation of Dr. Katherine Kemp some forty wives of members of the Academy, met at luncheon in the Hutzler's Tea Room, at noon, October 21, 1953, to consider the idea of organizing a "Ladies Auxiliary" to the Maryland Academy. The matter was discussed, approved, and the following officers were elected for 1954:

President: MRS. CHARLES F. O'DONNELL, 7501 York Rd., Towson

Vice Presidents: MRS. HAROLD B. PLUMMER, P.O. Box 95, Preston, MRS. MERRILL M. CROSS, Silver Spring, MRS. NATHAN E. NEEDLE, 6006 Park Heights Ave., Baltimore

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VA TO ASK FINANCIAL INFORMATION IN NON-SERVICE CONNECTED CASES

The AMA Washington Letter, No. 45

Under a new policy, Veterans Administration from now on will ask additional information from a veteran applying for hospitalization of a non-service connected condition. Previously, the veteran had only to answer the question: "Are you financially able to pay the necessary expense of hospitalization or domiciliary care?" If the answer was "no," the veteran was eligible. Now the veteran will be required to answer the following additional questions:

1. What is the current value of your property, real and personal? 2. What is the current amount of your ready assets in the form of cash, bank deposits, savings bonds, etc? 3. If you own real property, what is the approximate amount of the unpaid mortgage or other indebtedness? 4. What are your average monthly expenditures, including mortgage payments and all other personal expenses, including your expenses for dependents? 5. What was your average monthly income for the last six months, from all sources?

However, VA states that, "This addendum may be used in no way whatever to deny hospitalization to a veteran, as the law specifically provides that 'the statement under oath of the applicant . . . shall be accepted as sufficient evidence of inability to defray necessary expenses.' (It) is designed to protect applicants for hospitalization, and veterans generally, from charges of 'chiseling' on the government."

Scientific Papers

LATE COMPLICATIONS OF DIABETES: PREVENTION AND TREATMENT*

ALEXANDER MARBLE, M.D.†

For some years following the introduction of insulin in 1922 the experience with patients was so favorable and so encouraging that hopes were raised that the problem of diabetes had been solved. It soon became apparent that with insulin, acidosis and coma could be prevented and that, if they did occur, treatment was highly satisfactory if vigorous and if started early enough. Insulin enabled the diabetic to be brought safely through infections and surgical procedures which otherwise were hazardous. It was found that not only could glycosuria and hyperglycemia be controlled but also that hyperlipemia and hypercholesterolemia could usually be prevented. Above all, the length of life after onset of diabetes could be greatly prolonged. This was most striking among diabetic children and adolescents with whom diabetes in the past had been uniformly fatal after a short course of usually not more than 2 or 3 years and often less.

During these early insulin days the handwriting was undoubtedly being inscribed upon the wall but we were unable to read it clearly until some 15 or 20 years after insulin was first used, i.e., in the period 1937-1942. At that time those clinicians who had the opportunity of observing large groups of juvenile diabetics began to realize that after some 10, 15 or more years of

diabetes, these young patients often exhibited certain complications, chiefly of a vascular nature, which had a definite tendency to progression. One noted also that not infrequently there was evidence of deleterious effect upon the nervous system; neuropathies included not only peripheral neuritis but also paresis of the urinary bladder, "diabetic diarrhea," "neuropathic foot" and postural hypotension.

As the result of this experience in the insulin era the concept has arisen that the metabolic disturbance of diabetes, if held in check incompletely, gradually brings about harmful effects throughout the body. Such effects are seen most prominently in the vascular and nervous systems. The degenerative processes are operative at all ages but impress the observer most vividly when seen in the young. If diabetes has its onset at the age of 55 years, death from some vascular complication at age of 75 after 20 years of diabetes is not nearly so impressive as a fatal issue in a person of 35 years whose onset of diabetes was at age 15. For purposes of study these young patients are much more suitable because in them one can observe the effects of diabetes in pure form apart from the many influences which affect older persons and confuse the situation.

That the late complications of long-term diabetes constitute a major problem is now an established fact supported by the daily experience of patients and physicians everywhere. In the present paper an attempt will be made to answer the following questions: (1) How common are such complications, particularly of the

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vascular system? (2) What is their cause? How may they be prevented? (3) How can they be treated, if once present?

INCIDENCE

Retinitis. Retinopathy is one of the earliest evidences of vascular involvement and the one which from the patient's standpoint is often the most distressing. Characteristic are small, deep retinal hemorrhages or microaneurysms and waxy exudates. These tend to increase and as hypertension and renal disease develop, are joined by flame-shaped hemorrhages and fluffy exudates of the "cotton-wool" type. Hemorrhages into the vitreous may occur. Finally, fibrous tissue accompanied by new vessels may develop and extend until the full-blown condition of retinitis proliferans may occur. Blindness or near-blindness may develop.

In our own series of 451 patients, carefully studied,¹ with onset of diabetes under the age of 30 years and with duration of the disease from 10 to 36 years, the incidence of retinopathy was as shown in Table 1. It is evident that after 15 years of diabetes about $\frac{3}{4}$ of the patients had retinitis to some extent and well over half had the more severe grades. Such a high incidence is disheartening but one feels encouraged that over 40 per cent of the group showed little or no retinitis after 20 or more years of diabetes. The outlook is bad but not nearly as bad as has sometimes been stated.

Arterial calcification. Although arteriosclerosis, including atherosclerosis, is the most important foe of the older diabetic, it affects patients of all ages with long-term diabetes. In the older diabetic, presumably because of the additive effect of arteriosclerosis arising from influences apart from diabetes, this form of vascular disease is the greatest single cause of death. Thus, among 656 diabetic patients dying between 1950 and 1952, heart disease, chiefly arteriosclerotic in nature, accounted for 47.6 per cent of deaths.

TABLE 1
Incidence of Retinopathy in 451 Diabetic Patients with Long-Term Diabetes

DURATION OF DIABETES years	NUMBER OF PATIENTS	RETINOPATHY*	
		Grades 2, 3, 4 per cent	All Grades per cent
10-14.9.....	154	35	59
15-19.9.....	108	56	78
20 and over.....	189	57	73

* Retinopathy was graded as follows: Grade 1—few tiny hemorrhages and/or microaneurysms in one or both retinas with no exudates; Grade 2—several hemorrhages and/or microaneurysms in both fundi and a few to many hard and/or soft white exudates bilaterally; Grade 3—many hemorrhages and/or aneurysms bilaterally, some splinter hemorrhages in deep and superficial layers of the retina, and many exudates in both fundi; Grade 4—retinitis proliferans, retinal detachment and acute or chronic hemorrhagic glaucoma.

In the same series of 451 young patients just mentioned in whom diabetes had been present for 10 to 36 years, a study of the incidence of arterial calcification was made. It was realized that the flecks and lines seen in x-rays of the aorta, pelvic arteries and vessels of the legs represent calcium deposits in the media of arteries and may not give an accurate impression of the incidence of arteriosclerosis in general. However, this method of study was chosen because of the ease with which it could be carried out and the difficulty of devising any better way. The results are shown in Table 2.

Nephropathy. Experience has shown that the renal disease of the person with long-term diabetes is a mixed nephropathy² to which arteriosclerosis, arteriolarsclerosis, acute and chronic pyelonephritis and intercapillary glomerulosclerosis all contribute. Although the basic lesions are only in part vascular in nature, diabetic nephropathy may rightly be included among the vascular complications of diabetes. It occurs not only in older diabetic patients but frequently and most characteristically in relatively young persons in their thirties and forties who have had diabetes for 15, 20 or more years. Clinically diabetic nephropathy is manifested

Late Complications of Diabetes

TABLE 2
Incidence of Arteriosclerosis in 451 Patients with Long-Term Diabetes

DURATION OF DIABETES years	NUMBER OF PATIENTS	ARTERIAL CALCIFICATION*			
		Minimal	Mod.	Marked	Total
		per cent			
10-14.9.....	154	28	12	10	50
15-19.9.....	108	18	20	26	64
20 and over.....	189	16	19	49	84

* Arterial calcification was graded as follows: Minimal—one or more specks of density in linear arrangement in one or two small areas not over 1 or 2 cm. in length, with no calcification visible in the remainder of the arteries of the lower legs and pelvis and aorta; Moderate—tiny areas of density arranged in linear form in parallel order for lengths of more than 1 or 2 cm. in one or more arteries; Marked—more extreme degrees of density in the arteries and their branches in the legs and pelvis or in the aorta.

by albuminuria, hypertension, retinopathy, peripheral edema and azotemia, progressing to death, usually in uremia. Among our study group of 451 patients, there were 101 or 22 per cent who showed definite evidence of diabetic nephropathy. In recent years renal disease with ultimate failure has loomed increasingly high as a cause of death among patients with onset of diabetes in childhood and adolescence. Among 119 such patients dying between January 1, 1950 and August 31, 1953, nephritis accounted for 75 or 63 per cent of the deaths (see Table 3).

TABLE 3
Causes of Death in 600 Patients with Onset of Diabetes under the Age of 15 years

Period	1898 1922	1922 1936	1937 1943	1944 1949	1950 1953
No. of Patients Dying	157	99	81	144	119
CAUSE OF DEATH	per cent	per cent	per cent	per cent	per cent
Coma.....	86.0	56.6	27.2	9.7	6.7
Coronary.....	—	—	2.5	10.4	5.9
Nephritis.....	—	2.0	12.3	36.8	63.0
Cer. Vasc.....	—	—	1.2	2.1	5.9
Infections*.....	6.4	23.2	24.7	6.9	8.4
Tuberculosis.....	—	8.1	9.9	11.1	1.7

* Excluding tuberculosis.

Compiled by Statistical Department, Metropolitan Life Insurance Company.

Etiology and Prevention

It is far easier to arrive at figures for the incidence of vascular disease among diabetic patients than it is to demonstrate the cause. In fact, the etiology of such complications is at present the most disputed point in the field of diabetes. On the one hand there are those who believe that the development of degenerative complications is simply a matter of time and not dependent upon the degree of control of diabetes. Proponents of this idea often have suggested that some unrecognized "X" factor, running concurrently with the diabetes, may be responsible. They maintain that all that is necessary in treatment is sufficient dietary restriction and insulin treatment to keep the patient free from ketosis and overt diabetic symptoms. In general, such clinicians pay little or no attention to hyperglycemia or glycosuria. On the other hand are those who regard the vascular complications of long-term diabetes as directly related to the degree of control of diabetes over the years. These clinicians believe in controlling hyperglycemia and glycosuria as closely as possible short of producing frequent or severe insulin reactions. They believe that vascular disease is due directly to the poorly understood metabolic disturbance of diabetes of which a high blood sugar, urine sugar and ketosis are easily measured surface manifestations. Duration of diabetes is of importance chiefly in allowing more time for the harmful influences arising from the incompletely controlled diabetic condition to have their effect.

The writer aligns himself with the latter group and believes firmly that with the means of treatment now available, careful control of diabetes over the years is the only way to prevent or postpone the long-term complications of diabetes. This belief is based not only on clinical impressions but also on the results of a careful study of the 451 youthful patients to which reference has already been made. In this survey, the degree of control of diabetes maintained by patients over 10 to 36 years was graded. In

addition, the presence and/or degree of retinopathy, arterial calcification and nephropathy were carefully noted. Then the two types of data were matched in an attempt to discover correlations, if any. Among 32 patients who had maintained excellent or good control for 20 or more years, none had grade 4 retinopathy and one had grade 3 changes. No patient with excellent control had more than minimal (grade 0 or 1) retinopathy. On the other hand, among 157 patients with diabetes of the same duration who had maintained only fair or poor control, 26 (16%) had grade 4 retinopathy, and an additional 24 (15%) had grade 3. Among 189 patients with diabetes of 20 or more years' duration, 60% of the 32 with excellent or good control had either no arterial calcification or only minimal changes, whereas only 20% of 157 patients with fair or poor control had only these lesser degrees of arteriosclerosis. None of the 11 patients with excellent control and only one of the 50 with good control showed diabetic nephropathy; however, 17% of 92 patients with fair control and 28 per cent of 298 patients with poor control gave evidence of this condition. It seemed evident to us from this study that at all stages of duration of diabetes, the incidence of retinopathy, arterial calcification and nephropathy was significantly less in patients who had maintained excellent or good control of diabetes over the years. The obvious conclusion was that by careful and continuous control the long-term complications of diabetes may be prevented or postponed.

TREATMENT OF COMPLICATIONS

Until such time as the prevention of the late vascular and nervous system complications of diabetes becomes more nearly possible, it is the responsibility of the physician to deal with the problem as best he can. As has already been brought out in some detail, we believe that if one were able to bring about "Ideal" control of diabetes, with entire freedom from ketosis, hyperglycemia and glycosuria over years of

time, such could be taken as an indication that harmful influences arising from underlying metabolic abnormalities had been counteracted. In such an ideal situation, one might reasonably expect absence of specific sequelae of diabetes. At present those degrees of control which we call "Excellent" or "Good" do not approach closely the level of "Ideal" control and hence complications continue to occur in spite of our best efforts. In dealing with them, the best treatment now available consists in bringing the diabetic condition under the best possible control and maintaining it at this level. This is accomplished by the furnishing of a truly adequate though restricted diet and by the giving of appropriate doses of that type of insulin best suited to the individual. Clinical experience shows that in this way we may justifiably hope to stay the progress of the degenerative lesions. However, one would like to use supporting measures and in the following discussion the experience of our group will be cited.

Retinopathy. First, as regards retinitis, we have found no specific remedy. For years we used rutin and related substances and, at times, with apparent benefit. However, as time has gone on we have become increasingly of the opinion that these drugs are not effective, at least when given orally. The same applies to ascorbic acid although certainly one should not withhold this vitamin from anyone with whom there is any suggestion of a specific deficiency. Vitamin B complex and its various component B vitamins have not yielded success. Lately, on the basis of the animal studies of Friedenwald,³ we have treated a series of patients with injections of sizable doses of Vitamin B₁₂ over weeks of time without definite benefit. Finally, with the dreaded retinitis proliferans, we have not seen consistent or lasting success with the use of cortisone, ACTH or x-ray treatment.

Arterial calcification. As with retinitis, it is far easier to devise a theoretically effective means for prevention of arteriosclerosis than it is to treat the complication once it occurs. All

signs point to the conclusion that if diabetes is kept under excellent control, if obesity is avoided and if the blood lipids and blood cholesterol can be kept at normal levels, degenerative changes in the walls of blood vessels may be postponed. Once arteriosclerosis is present, these measures may conceivably check progression. Evidence suggests that it is more important to avoid overnutrition and obesity than it is to restrict arbitrarily the amount of fat and cholesterol in the diet. Following the work of Gofman and associates⁴ in which it was shown that patients with myocardial infarctions had increased levels of lipoprotein molecules with S_r 10-30, the thought arose that, in addition to dietary treatment, such persons might be helped by injections of heparin. Some have reported improvement in angina pectoris by such treatment. In our own patients a carefully controlled study designed to test the efficacy of heparin in patients with peripheral vascular disease and intermittent claudication, gave no positive evidence of benefit.

The principles of treatment of the patient with angina pectoris, coronary sclerosis and myocardial infarction are the same in diabetics as in non-diabetics. However, experience forces one to the conclusion that the prognosis in the diabetic is in general not as good. Hence the diabetic must be watched even more carefully and therapeutic measures designed with even greater thought. Hypoglycemia due to insulin must be avoided but this does not by any means imply, as sometimes taught, that insulin should be discontinued in the diabetic who develops a myocardial infarction. In fact, the diabetic condition should be well controlled, always taking care to avoid overdosage with insulin.

Time and space do not permit an adequate discussion of the treatment of peripheral vascular disease. However, one should emphasize again the familiar but often disregarded fact that, despite impairment of circulation, a high percentage of the instances of gangrene with or without infection may be prevented by careful, daily care of the feet and the early treatment of

small lesions if they do appear. In this field the sulfonamides and the antibiotics have proved to be a real blessing; with the use of a carefully selected antibacterial agent many extremities may be saved and conservative rather than radical surgery be possible. The guiding principles of treatment in the patient with gangrene and infection are as follows: (1) early recognition and prompt institution of treatment; (2) complete bed rest; (3) use of the appropriate antibiotic in adequate dosage; (4) careful control of the diabetic condition with the supplying of a diet adequate in protein and vitamins; (5) such early surgery as is necessary to provide free drainage from areas of infection; and (6) definitive surgery at a carefully selected time with the thought of being as conservative as is consistent with healing of the operative wound. We have found the transmetatarsal amputation to be an extraordinarily useful procedure which in many patients has happily taken the place of a higher procedure at the lower leg or low thigh level. As secondary measures in treatment, we have been disappointed with the results of all drugs introduced thus far to improve circulation by vasodilatation. One procedure, lumbar sympathectomy, has seemed of value in those few patients in whom careful clinical observation has suggested that vasospasm may be playing a significant role. Sympathectomy in the average elderly diabetic with gangrene has proved useless.

Nephropathy. Once diabetic nephropathy has developed with its proteinuria, diminished renal function, azotemia, lowered serum protein and reversal of the A/G ration and with common accompaniments of hypertension, retinopathy and varying degrees of generalized arteriosclerosis, the capabilities of the physician are put to a severe test. The best that one can hope for is to stay the progress of the disease and often it does seem that with careful control of diabetes and meticulous attention to supporting measures, a good deal may be accomplished to prolong life and make it more comfortable and useful.

It is amazing at times to see patients who carry on at their jobs over months or even years with constant mild to moderate azotemia. Much help is gained from sensible restriction of activity, restriction of sodium in the diet, and the use of ammonium chloride and mercurial diuretics. Certainly, however, nephropathy is a condition to be prevented rather than treated.

Neuropathy. Earlier in the discussion mention was made of the influence of diabetes on the nervous system and the various types of neuropathy which may occur, particularly after some years of poor control. As a complication of long-term diabetes, neuropathy of some degree and of some form or other is relatively common. When seen as a full-blown peripheral neuritis it may be extremely unpleasant and even disabling for the patient and exasperating for the physician. Fortunately, if the diabetes is brought under control and kept in that state and if an adequate diet is supplied, the eventual prognosis is good. Pain finally disappears although it may take weeks, months or even years for relief to come. As accessory treatment we prescribe large amounts of vitamin B although rarely does one observe any specific or dramatic effect. Over the years we have used injections of crude liver extract, vitamin B complex, thiamine, British Anti-Lewisite, pregnant mammalian liver extract and finally vitamin B₁₂. With each of these agents we have in certain patients observed improvement which has seemed related to the treatment but it has been extremely difficult to be sure whether the results have been truly specific. One must be wary in drawing conclusions when the course of the disease is variable and ultimate relief from pain is to be expected anyway and when so many different agents seem at times to have been effective. Certainly the last word has not been said as regards the treatment of diabetic neuropathy.

SUMMARY

In the three decades since the introduction of insulin the mortality from diabetic coma has fallen steadily. With the additional aid of the

sulfonamides and the antibiotics, deaths from infections and from surgical complications have been greatly reduced. The greatest problem and the greatest challenge now lie in the late complications of diabetes affecting particularly the vascular and nervous systems. Although these are found in diabetics of all ages, they are most tragic when they occur in persons in their 30's or 40's who after 15, 20 or more years of diabetes are beset with retinitis seriously limiting vision, hypertension, vascular sclerosis and nephropathy. Many of these patients will have had symptomatic neuropathy during their diabetic lives. In this group of relatively young persons death takes place most commonly from renal involvement.

Treatment of these conditions, once established, leaves much to be desired. The greatest hope lies in prevention. Unbiased clinical studies among patients with onset of diabetes below the age of 25 years have shown that the most important influence is the degree of control of diabetes. Duration of diabetes is important but chiefly because it allows a greater number of years for deleterious influences to operate. It is those patients with the best control who after 20 years have the fewest and least marked degenerative changes. Conversely, it is among those patients whose diabetes has been least well controlled that one finds the most distressing sequelae of long-standing diabetes. Careful, continuous control must be the aim of the physician in the care of his diabetic patients.

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A NEW TREATMENT FOR BRONCHIAL ASTHMA*

CHARLES F. GESCHICKTER, M.D.[†]

The asthmatic has a twofold allergic response. The first to develop is the serologic response in which neutralizing antibodies against pollens, dusts, and other substances circulate in the serum. For several years this reaction usually produces no symptoms, and the patient is in a balanced allergic state, to use a phrase introduced by Vaughn.¹ The second response appears later after damage and inflammation of the bronchial tree has occurred as a result of repeated contact between the immune serum and the inhaled antigenic substances. This leads to a second group of immune bodies (sessile antibodies), which attach themselves both to the injured bronchial tissue and the offending substances, so there is localization and intensification of the allergic response in the respiratory tissues. This localizing response, which liberates among other substances both histamine and choline and which is associated with hypersecretion and muscle spasm in the bronchi, tends to be more persistent and self-perpetuating and converts the bronchi into a shock organ where the fixation response produces further local inflammation, creating more tissue damage and stimulating further the production and fixation of antibodies. The patient now develops cough, wheezing and dyspnea, characteristic of asthma.

The twofold problem of asthma therapy may be stated as follows: We must either increase the neutralizing bodies in the serum through repeated inoculation, so-called desensitization, or depress the inflammatory response in the shock organ. Neither procedure is curative regardless of the success of treatment along these lines as long as the asthmatic retains his inherited tendency to hyperimmune response.

After an interval of two to six years without therapy he is capable of acquiring a second time both the serologic and shock organ responses which led to the original asthmatic attack. At times removal to a new environment or eliminating the offending substance will allow the susceptibility to remain dormant for want of a provocative agent. At other times the reticuloendothelial system of the asthmatic will show involutional changes as his age advances, which will eliminate the asthmatic tendency.

The new method of asthma therapy reported here represents an attempt to provide a therapeutic agent which localizes in the respiratory tissue at the site of concentration of the fixation antibodies. For this purpose the nucleus of the quinine molecule, which is 6-methoxy-4-amino quinoline, was selected. During World War II such quinoline compounds synthesized as antimalarial were shown to localize in both the respiratory tissue and in the reticuloendothelial structures. Expressed in terms of milligrams per kilogram of tissue (as measured in the monkey on daily doses of 25 mg. per kg. over a period of 30 days) showed the following tissue localization.

Plasma	0.6 mg./kg.
Brain	10 mg./kg.
Heart	20 mg./kg.
Kidney	30 mg./kg.
Spleen	40 mg./kg.
Lung	50 mg./kg.
Liver	70 mg./kg.

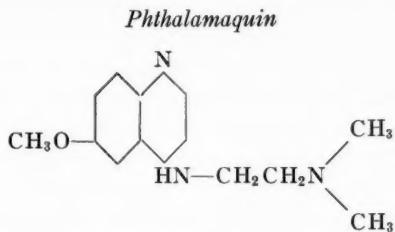
It will be seen that the maximum concentration of 4-amino quinoline is in the lungs and in the liver. This accounts for the pulmonary congestion observed in rats on high toxic chronic dosage and the finding of anorexia and sub-clinical jaundice observed in a patient on 5 mg. per kg. daily for a period of several weeks. The

* Supported by The Geschickter Fund for Medical Research, Inc.

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anorexia and liver function returned to normal several days after withdrawal of the drug. Complete blood studies before and after therapy on the patients in this series showed no untoward effects on the formed elements of the blood.

Since the quinine nucleus has been previously shown by Wolf² to be anticholinergic and, therefore, a probable bronchial dilator, it would seem likely that by adding a suitable side-chain the quinoline nucleus could also be made antihistaminic. The final compound synthesized, 4-(4-Dimethylamino Ethylamino)-6 methoxy quinoline, has the following structure:



(Distributed & manufactured by the New York Quinine & Chemical Works, Inc., N. Y. C.)

This compound has both bronchial dilator and antihistaminic properties, as well as an unusual advantage of localizing in the respiratory tissues. It has been termed Phthalamaquin, and it is administered clinically either orally or intramuscularly in 50 mg. doses in the form of organic salt. The 50 per cent lethal dose for rats is 100 to 150 mg. per kg. depending upon the organic salt used. The safe chronic toxicity level is 50 mg. per kg. daily over a period of six or more weeks. In long continued clinical use the safe oral dose is 3 mg. per kg. in human beings. Assays of the antihistaminic and bronchial dilator action of the compound on the tracheal ring of guinea pigs is shown in the accompanying graphs (Figs. 1 and 2).

A series of 285 cases of bronchial asthma have been treated a year or longer with Phthalamaquin.[‡] From the standpoint of treatment the

[‡] All of these cases had been previously treated elsewhere by a variety of methods, and considered therapeutic failures.

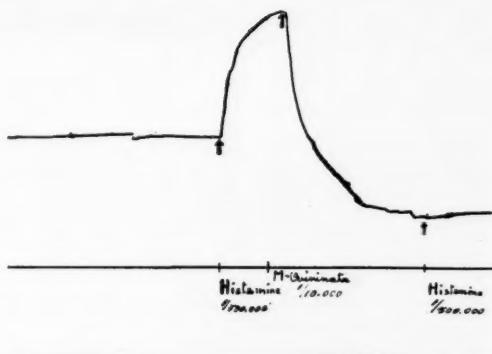


FIG. 1. Antihistaminic and bronchial dilator action of 4-(4-dimethylaminoethylamino)-6 methoxy quinoline, quininic acid salt (laboratory symbol M-quininate or MQ) on the tracheal ring of the guinea pig suspended in van Dyke-Hasting solution. The base line in front of the arrow to the left shows the normal tonus of the bronchial musculature. The upward curve from the first arrow follows the addition of histamine phosphate 1:500,000 to the physiologic bath. The second arrow shows the addition of the quinoline derivative (1:10,000) which obliterates the histamine reaction and dilates the bronchial musculature below the original base line. The third arrow shows the obliteration of the histamine response when the second dose of histamine is added.

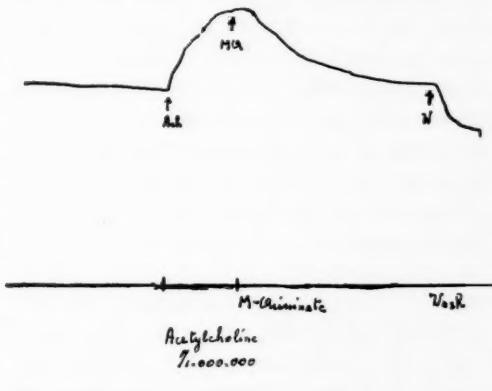


FIG. 2. Anticholinergic effect of 4-(4-dimethylaminoethylamino)-6 methoxy quinoline, quininic acid salt, on the tracheal ring of the guinea pig suspended in van Dyke-Hasting solution. The base line in front of the arrow to the left shows the normal tonus of the bronchial musculature. The upward curve from the first arrow follows the addition of acetylcholine 1:1,000,000 to the physiologic bath. The second arrow shows the addition of the quinoline derivative 1:10,000 which depresses the cholinergic response and continues to cause bronchial dilatation below the base line after the quinoline compound has been washed from the solution.

Schedule of Oral Quinoline Therapy for Control of Bronchial Asthma

	INITIAL THERAPY			MAINTENANCE THERAPY		ADD DURING ATTACK‡	
	Duration	Phthalamaquin	T.P.*	Continus 2 to 3 months			
				Aureoquin	T.P.*		
Children under 4	2 weeks	3 mg./kg. q.d.	15 mg. q.d.	2 mg./kg. q.d.	15 mg. q.d.	180 mg. 1X or 2X daily	
Children over 4	3 weeks	50 mg. b.i.d.	15 mg. b.i.d.	50 mg. q.d.	15 mg. q.d.	250 mg. 1X or 2X daily	
Adults†	3 weeks	50 mg. t.i.d.	15 mg. t.i.d.	50 mg. b.i.d.	15 mg. b.i.d.	250 mg. b.i.d. or t.i.d.	

* Thenylpyramine.

† Digitalize cardiacs.

‡ Injections of Phthalamaquin 150 to 250 mg. intramuscularly and give aminophylline-OH orally.

cases have been divided into 155 children, 50 young adults, and 80 adults over 40 years of age. In the juvenile group there were 2.5 per cent failures; in young adults 5 per cent failures; and in adults over 40, 10 per cent failures. About 25 per cent of the cases showed complete symptomatic remissions for periods of two to four years after therapy was discontinued. The schedule of dosage used is shown in the accompanying table.

It is important to separate the patients with bronchial asthma into the different age groups specified above. In children the chief etiological factor is upper respiratory infection. Their asthma is often mild and of brief duration and responds more readily to therapy.

In young adults, pollenosis, which requires a long latent period before it becomes clinically manifest, is a leading etiologic factor, and dosage must be regulated for the peak seasonal loads.

In adults over 40, emphysema and cardiac complications are important considerations from a therapeutic standpoint. In the present series of 80 cases of bronchial asthma in patients over 40, 75 per cent had pulmonary emphysema, and 20 per cent had cardiac complications in the form of left ventricular damage. In the cardiac cases, digitalis therapy is an important adjunct to treatment, and these patients must be evaluated by electrocardiogram, venous pressure, and circulation time.

In all cases, the quinoline derivative was combined with thenylpyramine in the ratio of 50 mg. of quinoline to 25 mg. of thenylpyramine. This therapy is administered orally as tablets or capsules two to three times daily for several months. A smaller dose is used in children under five years of age. This constituted the suppressive therapy which was responsible for the satisfactory control of the asthmatic cases treated. Improvement is usually manifested in several days to two weeks. In the event of acute attacks, the therapy was supplemented by oral or intravenous administration of a new theophylline salt, theophylline diaminopropanol. (Referred to in the table as aminophylline-OH) The aminophylline-OH is added rather than increasing the dosage of Phthalamaquin because bronchial irritation may be provoked by overdosage with this medication.

These compounds were synthetized by Dr. Leonard Rice at the Georgetown University Medical Center in consultation with Dr. E. Emmet Reid, Professor Emeritus, Johns Hopkins University, Baltimore, Md. The bio-assays on animals were performed by Dr. Antoinette Popovici at the Georgetown University Medical Center.

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TENDON SUTURES

ERWIN R. JENNINGS, M.D.*

There are many varied sutures used in the repair of severed tendons. Because of the parallel arrangement of the tendon fibers, most tendon sutures take up a criss-cross or interweaving pattern. The type of suture used is probably not as significant as the trauma incurred to the tendon and surrounding tissues when applying the suture.

Recently a new type tendon suture was introduced in this country by Dr. George H. Yeager. The suture was originally designed by an Austrian surgeon, Dr. Fritz Lengemann. The suture in current use is a 12 inch braided tantalum wire which has a straight needle on the distal end, and a curved needle on the proximal end. Approximately 8 inches from the straight needle there is a V-shaped steel barb, which is applied in such a manner that the prongs of the barb point toward the straight needle. When suturing a severed tendon, one introduces the straight needle into the proximal segment $\frac{1}{2}$ inch from the divided end. The barb is engaged into the substance of the tendon and the straight needle then introduced through the distal segment and carried on out through the skin. Enough tension is applied to the suture to approximate the divided segments, and this tension maintained by means of a button and lead shot. The proximal portion of the suture is inserted through the skin proximally and threaded loosely through the button. After healing of the tendon, the distal button is removed, and the suture disengaged by pulling proximally. Due to the fact that this is primarily a core suture, and very little trauma is usually required for its introduction, it was postulated that this might improve the notoriously bad results characteristic with divided flexor tendons. The age old problem of severed tendons within the flexor digital sheath has presented a par-

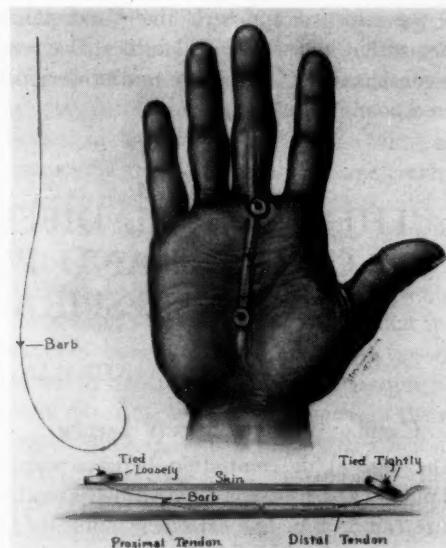


FIG. 1

ticular challenge. The results thus far obtained with 24 flexor tendons are still far from perfect (Table I). Of 16 tendons severed within the flexor digital sheath, only 8 were considered to give good results. However, of 8 tendons severed outside the flexor digital sheath, all 8 gave good results. Because of the relative ease of repairing extensor tendons, the use of this suture is not considered necessary.

The criteria for classifying results as good, fair, or poor, are based primarily on the ability or the inability to touch the distal palmar crease with the tip of the affected finger. If the

TABLE I
Results of Flexor Tendon Repair

	GOOD	FAIR	POOR	TOTAL
In Sheath.....	8	4	4	16
Not in Sheath.....	8	0	0	8
Total.....	16	4	4	24

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distal palmar crease was approached within a distance of 1 inch, the result was considered good. If the finger was able to carry out coarse movements, with no true functional disability, and was able to approach the distal palmar crease within a distance of 2 inches, the result was considered fair. All other results were considered poor.

This series is too small to evaluate the barb wire suture in comparison to other techniques. It must suffice to say that because of the speed and ease of appliance, the over-all decrease in trauma to the tendon and surrounding tissues, this suture may prove to be a useful tool in applying the basic principles essential in hand surgery.

THE CLINICAL DIFFERENTIATION BETWEEN CARDIAC AND PULMONARY DISEASES IN RESPIRATORY FAILURE*

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CARDIAC AND PULMONARY FAILURE

The clinical differentiation between cardiac and pulmonary disease in a patient in respiratory failure can at times be extremely difficult. The diagnostic challenges are presented by patients who have had long standing respiratory disease and who are old enough to be candidates for degenerative heart disease. The problem is whether the failure is due to primary pulmonary disease or is the heart failing now as well. This question not only is extremely important for therapeutic reasons but for prognosis and for medico-legal aspects arising in compensation cases of occupational diseases.

By "clinical" differentiation is meant the facilities the physician has at hand to make a diagnosis in a moderate sized non-teaching institution. This, of course, includes routine laboratory studies, x-ray and electrocardiography. It would not include elaborate studies for pulmonary gas analysis nor the use of a physiological laboratory for detailed O₂ saturation studies, radioactive tagged ions etc. In other words with reasonable facilities available,

can one, confronted by a patient in respiratory failure, differentiate the condition as being due to the failure of the cardiac or pulmonary mechanism?

It would be well to classify briefly those respiratory diseases which cause pulmonary failure. To simplify this let us first classify those respiratory diseases which frequently cause difficulty in differentiating them from cardiac failure (Group A) and those which once diagnosed would hardly cause much of a differential problem (Group B and Group C).

Group A

1. Bronchial Asthma
2. Asthmatic Bronchitis
3. Pneumoconiosis
4. Emphysema
5. Bronchiectasis

Group B

1. Infections
 - (a) Lung abscess, tuberculosis, fungus, etc.
2. Neoplasms
3. Mechanical Obstructions
 - (a) Foreign bodies
 - (b) Mediastinal masses; lymphadenopathy; aneurysms, etc.

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Group C**1. Respiratory neurosis**

Before attempting a differentiation one should have an adequate concept of heart failure. It is not the purpose of this report to discuss the etiology of heart failure. Authorities are far from agreement as to the exact pathogenesis of failure. Some feel the primary etiological site may not even be in the heart but in the kidneys or adrenals or in the pituitary-adrenal axis etc. However, we do know that in cardiac failure there is fluid in the extracellular spaces that should not be there.

The respiratory tract assumes the most prominent position in heart failure. Early evidences of failure begin here and persist with increasing severity till the patient expires from pulmonary edema. The very first symptom of heart failure is breathlessness. If the left ventricle weakens and pumps out less blood than the right ventricle pumps in, then pulmonary congestion ensues and dyspnea starts. This is seen mostly in hypertensive and coronary artery disease.

Paroxysmal dyspnea is the key episode confronting the physician in the differentiation of respiratory failure. This nearly always occurs in bed in both cardiac failure and in the asthmatic paroxysms of respiratory disease. There is a fairly sound physiological reason why nocturnal dyspnea due to left ventricular failure occurs. Lying down facilitates a slight gradual shift of fluid from the periphery to the pulmonary circuit. Venous return from the legs is enhanced and the blood volume increases. These factors increase the return to the left auricle, which now expels a little more blood into an already weakened left ventricle and the latter promptly fails. In addition sensory perception is diminished during sleep and reflex stimuli from congested lungs, which are extremely important in clearing the pulmonary bed, are less effective during sleep. Finally after an excessive accumulation has occurred in the lungs the respiratory center will respond vigorously to stimuli. This

results in laborious breathing with slight or marked pulmonary edema. The accompanying cough will only aggravate further the vicious cycle of pulmonary distress. There is only one effective way of blocking this vicious cycle of bombarding stimuli and that is by morphine. Other disturbing stimuli which occur at night that may set off such a chain reaction are a full bladder, abdominal distention and unpleasant dreams. These neurogenic cycles are nearly always effectively broken by morphine and it is for this reason that morphine is so valuable in severe paroxysmal dyspnea.

With right sided failure the right ventricle can not expel efficiently all the blood that it was meant to handle, as evidenced by the early increase of venous pressure. This is most often seen in mitral stenosis. Engorgement of the neck veins occurs as well as hepatic congestion, visceral congestion and dependent edema. With hepatic and visceral engorgement, epigastric distress, right upper quadrant pain and marked digestive disturbances can occur. In the late stages ascites develops, causing considerable difficulty. Significant venous and visceral engorgement can occur in ambulatory patients without edema because the muscle action of the legs efficiently "pumps" blood back up toward the heart. Rarely does one sided failure exist in pure form; the combination is nearly always seen.

Insofar as the physical examination of the heart is concerned there are only a few significant findings to indicate failure. The presence of a diastolic gallop rhythm or a pulsus alternans generally indicates failure. An accentuated P_2 signifies increased pulmonary pressure but this varies with the observer. Cardiac enlargement with all the above signs and symptoms is the "sine qua non" of heart failure. However, murmurs, irregular rhythm and cardiac enlargement alone do not indicate the presence of heart failure.

The most significant factors in determining cardiac failure are a few objective procedures.

These are not complex and are easily interpreted and extremely important.

1. *The Vital Capacity Determination:* This is easily done with a spirometer. Normally the average adult has a total breathing space of about 4000 cc. and inhales 400 cc.-500 cc. with each breath and on effort can increase the rate and depth of respiration without distress. If his vital capacity is reduced it is easily detected with a spirometer.

2. *Venous Pressure Determination:* This is determined with a manometer connected to an antecubital vein by a 20 gauge needle. Normal values are 400 mm.-80 mm. of water. This test is extremely important in doubtful cases of congestive failure.

3. *Circulation Time:* The velocity of blood flow can be determined by injecting a testing solution into an antecubital vein. Its arrival at the tongue is signaled by the unique taste of the substance. Such solutions are Decolin 3 cc. to 5 cc. of 20% solution; end point bitter; 2 Gm. to 3 Gm. of Saccharin in distilled water; end point sweet; Calcium Gluconate (2.5 cc. 20% solution); end point is warmth. Caution should be used in digitalized patients because of synergistic action of calcium and digitalis. In testing, the patient should be recumbent; the injections rapid and the end point accurately timed by a stop watch. Normally the end point is about 15 seconds; in marked congestion it may be 25 to 50 seconds.

4. *Blood Volume:* Normal volume is about 5000 cc. In failure it may increase to 6-7 liters. This is one of the most constant changes that accompany heart failure. Excess blood is stored in the venous circulation, the lung, and to some extent in the dilated heart. The test is relatively simple when carried out by the dye absorption method. This is similar to a Bromsulphthalein liver function test. A measured quantity of dye is injected intravenously and the dilution is determined.

5. *Chest X-ray:* The P.A. view of the chest in significant heart failure will show pulmonary

congestion and an enlarged heart. Pulmonary congestion is first demonstrated by a "sun-ray" pattern of increased bronchial markings, extending from the hilar area. Cardiac enlargement is usually obvious to the eye but can be measured. There are measures based on mass and density for heart measurement; but if there is equivocation, these measurements are of little value in making a positive diagnosis of heart failure.

With the recognition of heart failure and its objective determination we can now return to the respiratory diseases that cause pulmonary failure. In all of these we are considering respiratory diseases that are long standing. Therefore, patients for this consideration will range from the 4th decade on.

BRONCHIAL ASTHMA

It is unnecessary to describe the clinical picture of the patient with classical bronchial asthma. He is one with a long standing allergic background, sensitive to inhalants and now condemned to a life of emphysema. The bellows action of his chest cage is practically nil, his exchange of tidal air in his lungs is minimal and he sits up in an orthopneic position; his neck sunk into the thoracic cage. How do we know he is not in cardiac failure? Obviously his vital capacity is low, he is cyanotic, orthopneic and dyspneic but he is not in cardiac failure if he fulfills the following criteria: An x-ray of the chest showing a normal or frequently a small heart in addition to extensive emphysema. Circulation time and venous pressure normal along with a normal blood volume. No venous engorgement; the liver not enlarged and no dependent edema.

The electrocardiogram, which can never be interpreted as indicating heart failure can, however, indicate the presence of a damaged heart. Respiratory distress in cardiac decompensation is on the basis of left ventricular failure. The most common causes of left ventricular failure are hypertension and coronary artery disease.

When these conditions are sufficiently severe to cause heart failure they practically always will be accompanied by an abnormal electrocardiogram. A normal electrocardiogram in severe dyspnea would be added evidence that the dyspnea is not on a cardiac basis.

The clinical picture of the chronic asthmatic with emphysema differs little from that of the patient with asthmatic bronchitis, pneumoconiosis, emphysema or bronchiectasis. Actually asthmatic bronchitis may be considered with the old classification of intrinsic asthma. He is the patient who has had chronic respiratory infection for years and finally develops emphysema and asthma.

BRONCHIECTASIS

The patient with bronchiectasis who has gone into chronic pulmonary failure can be recognized by his general debility, and copious sputum that is frothy and may be in layers. His past medical history is marked with frequent episodes of respiratory tract infection, sinusitis, pharyngitis, bronchitis, etc. The bronchiectatic frequently has pulmonary arthropathy which is lacking in even the most severe of the other cases in Group A. If he is in pure pulmonary failure, although he will be severely dyspneic and cyanotic he will not necessarily be orthopneic and will have no venous engorgement, hepatic enlargement or edema. Three of the four objective findings (Venous Pressure, Circulation Time and Blood Volume) for cardiac failure will be normal. His electrocardiogram may well be normal and the clinching factor will be the chest x-ray. Bronchogram will nicely demonstrate the bronchiectatic areas and the heart size will be normal.

EMPHYSEMA WITH ANTHRACOSILICOSIS

Pure emphysema is not a common occurrence but it is extremely frequent as a complication of chronic respiratory diseases. A clinical combination is emphysema with pneumoconiosis and the two can be discussed as a clinical entity.

Because of our locale we shall select anthracosilicosis as our best example. The anthracosilicotic in respiratory failure presents a uniformly characteristic picture. His medical history is suggested by his pasty gray, sunken, apathetic countenance tattooed with the tell-tale blue marks of mine explosions. In spite of the marked decrease in vital capacity with severe dyspnea, we have frequently observed these miners to be free of orthopnea. Further differentials of these cases from cardiac failure include lack of venous engorgement, and lack of both liver enlargement, and dependent edema. The three objective tests for heart failure (see above) will be normal. The clinching diagnosis again in these cases is the chest x-ray. Here one sees the nodulations of silicosis ranging from small coalescences to massive nodules almost as big as baseballs. The remaining lung fields are extensively emphysematous. The cardiac silhouette will be normal or frequently small in size. If the electrocardiogram is normal this is further evidence of lack of cardiac involvement. However, it is possible that these older miners may show some electrocardiographic evidence of coronary disease; but if all the above objectives tests for heart failure are normal and if the heart size by x-ray is normal, then in spite of abnormal electrocardiogram one can state categorically these patients are not in congestive failure. The importance of the medico-legal aspects of this in compensation cases of occupational diseases is obvious.

There is rarely difficulty in differentiating cardiac failure from pulmonary failure due to diseases in Group B. Roentgenograms of the chest and laboratory findings quickly identify the etiology; furthermore chronic long standing cases rarely occur because of the limits set by the disease entities.

Group C can be divided into 3 categories:

1. The neurasthenic: This is usually a female, who has non-descript constant chest pain associated with a sighing type of respiration resembling dyspnea. Usually these symptoms

develop from close association with a relative or friend who has organic heart disease. Objective tests, of course, show an excellent vital capacity with all other tests normal.

2. The obese, dyspneic female with puffy ankles: She has probably been told by a physician at one time or another that she has a "bad heart" and even was hospitalized. The objective tests will all prove to be normal. Her problem, of course, is one of reassurance and weight reduction.

3. The hysterical: This patient, usually a female, may be so profoundly disturbed that her dyspnea develops into an over ventilating alkalosis and she actually incapacitates herself. Her objective cardiac tests will all be normal and she may be reassured by this or psychotherapeutic measures.

COR PULMONALE

When after years of pumping against a resistant pulmonary bed in patients with chronic pulmonary diseases, the right ventricle fails and failure associated with Cor Pulmonale may develop. This is diagnosed by finding abnormal objective tests for failure. The chest x-ray will show prominence of the right side of the heart and the electrocardiogram frequently will show a right ventricular preponderance.

MANAGEMENT OF CONGESTIVE HEART FAILURE

In pursuing the differential diagnosis of congestive heart failure from pulmonary failure the management of these conditions becomes an integral part of the picture. It is not the intention of this paper to give detailed therapy of all the diseases mentioned, but a comprehensive discussion of therapeutic management should be of differential value.

Bed Rest: This is of great importance but a flexible interpretation of bed rest is necessary. For example, patients with marked pulmonary congestion would do well to sit on a chair for the greater part of the day. "Water in the feet is unsightly but water in the lung will kill."

More liberal use of bathroom privileges should always be considered where indicated.

Sedation: Phenobarbital and bromides are of great value and morphine, as explained above in paroxysmal dyspnea, is of utmost necessity.

Diet: Suffice it to say that a low sodium diet has been proven of significant value in cardiac failure. It is improbable that one can obtain a daily sodium intake under 1 Gm. The value of a low caloric diet in a patient with a weakened myocardium is obvious.

Oxygen: Oxygen by mask in acute failure can be most effective. Overlooked frequently in patients with chronic failure is the fact that patients who are home and ambulatory or even doing light work may benefit immeasurably by oxygen administered as needed.

Digitalis: There is one universal indication for digitalis and that is congestive failure. In acute failure one should use the most rapid glycosides such as digoxin intravenously if necessary for it may prove life saving. As for chronic failure one should use the type of digitalis with which he is most familiar. Either digitoxin or the powdered leaf is effective.

Diuretics: With the patient on a low sodium diet the use of a mercurial diuretic intramuscularly or intravenously can produce a most gratifying type of diuresis. In fact if properly administered some authorities feel that a mercurial diuretic is the most important drug in the medical armamentarium for congestive failure. It is our feeling that oral diuretics are of no significant value. Ammonium chloride can be used to enhance the activity of the mercurial diuretic. With copious and frequent diureses one must be on guard against the salt depletion syndrome.

Aminophyllin: This is one of the most valuable drugs available for patients with cardiac failure who have respiratory symptoms. The patient who suffers at night with dyspnea can very often assure himself a comfortable night by the insertion of an aminophyllin suppository (0.5 gram). For the critically ill patients who have

early pulmonary edema a slow intravenous drip of 0.5 Gm. of aminophyllin in distilled water may be of great value. For the patient with severe paroxysms of cough and dyspnea, aminophyllin orally is of no value.

Phlebotomy: In acute pulmonary edema a situation will occasionally arise when a phlebotomy will be the only procedure that can be performed but it may be dramatically life saving. To be effective it should be done very rapidly. As large a needle as possible should be used and the entire amount of blood (400 cc.-700 cc. depending on the size of the patient) should be withdrawn in about 10 minutes.

Other Drugs: Quinidine, anti-coagulants, and anti-biotics etc. are used in failure when specifically indicated.

Mechanical Methods: Bloodless phlebotomies and Southey tubes are used rarely in some intractable cases of failure. Paracentesis of the chest and abdomen is, of course, done in advanced cases when indicated.

Differential Diagnosis in Therapeutic Consideration: With the above management of cardiac failure in mind let us return to the respiratory diseases in Group A.

BRONCHIAL ASTHMA

Measures such as rest, oxygen and sedation are indicated in bronchial asthma. A salt poor low caloric diet, however, would actually be contraindicated in an asthmatic who should have a good saline intake and a very nutritious diet. For the patient in a protracted seige of asthma the most valuable therapy is epinephrine and ACTH or cortisone. The use of these drugs in a mistaken case of heart failure would be tragic. The danger of epinephrine in an already weakened myocardium or in a hypertensive is obvious. One of the prime contraindications of ACTH and cortisone is heart failure because of the great tendency these drugs have for binding water and causing edema.

It has long been known that morphine in a case of intractable bronchial asthma can on

occasion be fatal. A phlebotomy would only aggravate the weakness of an already badly exhausted asthmatic. Digitalis and mercurials would have no value in these cases. They could be toxic in indiscriminate usage. It is extremely important to differentiate between these two types of respiratory failure.

PNEUMONOCONIOSIS WITH EMPHYSEMA

The management of these cases differ radically from that of heart failure. With the exception of aminophyllin and antibiotics none of the above cardiac therapeutic measures is used. The keystone of therapy is to reduce infection and encourage bellows action of the lungs. Prolonged use of antibiotics such as penicillin combined with iodides facilitates bronchial drainage. Guided breathing exercise with abdominal support encourages bellows action of the lungs. The administration of oxygen under positive pressure is being tried on anthracosilicosis but its value is still in doubt. When these patients develop bronchospasm, aminophyllin as used for congestive failure is of great value.

The management of bronchiectasis again differs radically from congestive failure management. Mistakenly treating a bronchiectatic with congestive failure measures would soon doom the patient. The management of bronchiectasis very briefly consists of three measures: (1) combat infections, (2) drainage and (3) surgery.

SUMMARY

The clinical differentiation between cardiac and pulmonary disease in respiratory failure is outlined. This challenging problem arises frequently and has many medical and non-medical implications. The differential is based mainly on relatively simple but important objective findings with symptomatic evaluation. Therapy is discussed in order to emphasize the extreme importance of making a proper diagnosis. The therapy of one disease mistakenly applied to another can not only be unfortunate, but tragic.

FULMINATING THROMBOPHLEBITIS MIGRANS

WILLIAM F. RENNER, M.D.^{1, 2}

Thrombosis and its complications constitute the most common mechanism of death in the older age group. Yet the pathogenesis of thrombosis remains poorly understood, although many of the predisposing factors are recognized. Change in the walls of blood vessels is a common antecedent factor to thrombosis. This factor operates in atherosclerosis, in thromboangiitis obliterans, and in septic thrombophlebitis. Changes in the constituents of the blood are thought to play a role in some cases of thrombosis. This is true in thrombosis associated with evidence of hypercoagulability, with the phenomenon of sludging, and with increased platelet adhesiveness.^{1, 2, 10} In cryoglobulinemia and in the syndrome of cold hemagglutinins, the cells of the blood agglomerate so as to obstruct the vessels and interfere with blood flow, a phenomenon very similar to thrombosis although the mechanism involved is probably fundamentally different.^{1, 2, 3}

The factor of stasis is well recognized and is known to play a role in the tendency to thrombosis in patients confined to bed and in congestive heart failure. Malignancy, particularly of the pancreas, may first manifest itself through a migratory thrombophlebitis. However, patients with a pronounced tendency to thrombosis are quite commonly seen in whom no abnormality of the blood and no systemic disease can be found to account for the thrombosing tendency. Familial thrombophilia and idiopathic thrombophlebitis migrans fall into this category. Cases of acute thrombophlebitis in young, ambulant, apparently healthy individuals are no longer considered a rarity.^{4, 5}

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² The author wishes to acknowledge the assistance of Walter Merkel, M.D., Pathologist, The Union Memorial Hospital and Jesse Hubbard, M.D., Resident in Pathology, The Union Memorial Hospital.

The subject of this report, while in apparently good health except for a moderately severe arterial hypertension, developed a remarkable acute thrombosing tendency which proceeded rapidly to a fatal termination. Despite therapy, a symmetrical gangrene of the lower extremities developed with evidence of involvement of an upper extremity and of the brain by the thrombotic process. The clinical course and pathological examination of one of the digits indicated that both arterial and venous systems were involved in the thrombophilia. The case is of particular interest because of the evidence of arterial involvement which is in contrast to previous otherwise similar case reports of thrombophlebitis associated with gangrene in which the gangrene appeared to be due to extensive venous thrombosis without organic arterial occlusion.

CASE REPORT

The patient, a 70 year old white woman, had enjoyed good health except for a moderately severe asymptomatic arterial hypertension. She gave a history of having "bruised easily" but otherwise had never exhibited abnormal bleeding. In other respects the past history was not remarkable.

On April 15, 1953, she presented herself complaining of multiple painful nodules on both legs of two weeks duration. These nodules had the typical appearance of a superficial thrombophlebitis. Thrombi could be palpated in the veins. The overlying skin was red and of increased temperature. Slight varicosities were present bilaterally. Arterial pulsations were normal. There was no evidence of deep vein involvement. The patient was advised to remain in bed with elevation of the legs. She was given aureomycin for four days because of the possibility of a recent upper respiratory infection playing an excitant role in the phlebitis. At the

end of that time the phlebitis appeared to be subsiding. Then new areas of phlebitis appeared and ankle edema developed. On May 4, two weeks after the patient was first seen, there was sudden onset of pain in the right chest, aggravated by respiration. Moist râles were noted at the right base for the first time. A diagnosis of pulmonary embolism was made, and the patient was promptly hospitalized.

On admission to hospital, temperature was 100° F., pulse 90, and the blood pressure 138 systolic and 84 diastolic. Moist râles were again noted at the right base. The left leg was considerably swollen with marked calf tenderness. The right leg was slightly swollen but not tender. The physical examination was otherwise not remarkable. Clotting time was 4'30" (capillary tube method). Bleeding time was 30". Hemoglobin level was 79.4% (11.5 Gm., Wintrobe). W.B.C. 9,900. Urinalysis normal. N.P.N. 35.5 mg. per 100 cc. Fasting blood sugar was 93 mg. per 100 cc. Platelet count 120,000. Alkaline phosphatase was 8 Bodansky units. Cephalin flocculation was reported as a trace in 24 hours. The serologic test for syphilis (blood) was negative. Except for a few days after the occurrence of the pulmonary embolism and a few days terminally, the patient was afebrile.

Therapy with heparin and dicumarol was initiated on the day of admission. Over a period of two weeks, the patient appeared to be gradually improving although new evidence of phlebitis continued to develop. Two weeks after admission, the patient developed severe pain in the left leg and foot and the left leg became extremely swollen from the knee down. During the course of the next 24 hours, a severe bluish discoloration of the distal portion of the foot and of the toes developed, with coolness of the skin. The distribution of the discoloration was patchy. The 3rd and 4th toes were most discolored, the 1st and 5th toes to a lesser extent. The 1st toe was involved in its proximal portion, the distal portion remaining quite pink and warm throughout the illness. The patchy dis-

tribution of cyanosis and the normal appearance of the distal portions of some of the toes was interpreted as indicating that if the arterial side of the vascular tree was being occluded small end vessels were undergoing thrombosis since characteristically occlusion of the main artery to a part causes severe ischemia in the distal portion of the part affected. It is to be noted that the pathological report, to be described below, supported such an interpretation. The severe edema nullified attempts to palpate the peripheral pulses.

The patient ran a rapidly downhill course. Vigorous effort was made to keep the prothrombin time within therapeutic range. When indicated, supplementary doses of heparin were given. Priscoline was administered parenterally. As the course continued downhill, therapy with ACTH was initiated in view of favorable reports in the literature of the effect of ACTH on the course of migratory phlebitis.

The left foot rapidly developed a superficial gangrene. The skin broke down in several areas and drained a sanguineous material. Six days after the discoloration first appeared in the left foot, the distal segment of the right foot became cool and painful and discolored. The discolored proceeded rapidly to gangrene. The gangrene of the two feet had a remarkable symmetry of distribution. On May 25 a hemiplegia of the left side of the body developed in a manner suggesting a cerebral thrombosis. Two days later, deep cyanosis of the 3rd and 4th fingers of the right hand appeared. There was no swelling of the fingers and no prominence of the veins, suggesting that the cyanosis was purely arterial in origin. Two days later the patient expired.

POSTMORTEM EXAMINATION

Unfortunately the autopsy was restricted to examination of one of the involved toes. The following is quoted from the microscopic description of sections of this toe. "The sections are characterized by an enormous dilatation of the vascular channels, including the capillaries.

The venules are distended to capacity, indicating apparently an obstruction to the venous side, because of the enormous dilatation and stemming back of the blood. The wall of a small artery is eccentrically thickened and the lumen is occluded by freshly clotted blood. Some of the venules show thrombi and along a few of these are an unusual number of leukocytes, and these are seen along the outer surface of the vessel, apparently not settled out by the stagnant blood."

COMMENT

Gangrene is a rare complication of thrombophlebitis. Haimonici, in an extensive review of the literature up to 1949, was able to collect only 28 cases of gangrene of an extremity secondary to venous thrombosis.⁶ Since this time at least four additional cases have been reported.^{7, 8, 9} The consensus of opinion regarding the mechanism of the gangrene in these cases has been that the massive venous thrombosis, involving both the main venous channels and the small tributaries, resulted in an ischemia of sufficient degree to lead to necrosis. This opinion has been based on the invariable absence of evidence of arterial occlusion in the specimens which were submitted to pathological examination. Some authors have felt that arteriospasm played a subsidiary role in the mechanism of the gangrene, but the general opinion has been that spasm of the arteries, if present at all, was of very little importance. In the case described above, there is clear evidence of arterial involvement. After gangrene developed in the lower extremities, two fingers of the right hand became cold and deeply cyanotic and undoubtedly would have gone on to gangrene had death not intervened. Late in the illness the patient developed a left-sided hemiplegia suggesting cerebral thrombosis. Post-mortem examination of one of the digits showed thrombosis of a small artery.

The question arises as to the proper classification of the disease which took this patient's life.

Thrombophlebitis is obviously an unsatisfactory term since it does not take into account the arterial thromboses. Thromboangiitis obliterans is a disease which is characterized by both thrombophlebitis migrans and arterial occlusion. However, the age and sex of the patient, the clinical course, and the absence of characteristic pathological changes make this diagnosis untenable. Thrombophilia, either essential or secondary to a hidden malignancy which might have been found had a complete autopsy been possible, would be an appropriate diagnosis were it not for the fact that this term has already been used by Nygaard and Brown to designate a thrombosing tendency associated with evidence of hypercoagulability, a condition which was not demonstrated to be present in this case.¹⁰

For want of a better diagnostic term in the current classification of diseases and in consideration of the fact that a migratory phlebitis was the outstanding feature, the case is considered as one of thrombophlebitis migrans of unknown etiology, complicated by arterial thromboses and by gangrene of the lower extremities. It is thought that venous and arterial thromboses played synergistic roles in the production of the gangrene.

SUMMARY

A case of fatal fulminating thrombophlebitis migrans with symmetrical gangrene of the lower extremities in an elderly female is presented. During the course of the illness evidence developed of organic arterial occlusion in the lower extremities, one upper extremity, and the brain, indicating that the thrombosing tendency involved both the arterial and venous systems. No abnormality of the blood clotting mechanism to account for the thrombosing tendency was detected.

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10. NYGAARD, K. K. AND BROWN, G. E., Essential Thrombophilia, Report of Five Cases, Arch. Int. Med. **59**: 82-106 (Jan.), 1937.
11. EDWARDS, E. A., Varieties of Thrombophlebitis and their Management, Modern Concepts of Cardiovascular Disease **21**: 154-157 (Dec.), 1952.

DRS. MARTIN AND CROSBY ON HOOVER COMMISSION'S MEDICAL TASK FORCE

The AMA Washington Letter, No. 44

Two physicians well known to the medical profession, Dr. Edwin L. Crosby and Dr. Walter B. Martin, have been appointed to the Hoover Commission's Medical Task Force. The Force will study all medical activities conducted by branches of the federal government. Membership will include physicians prominent in medical school activities, in public health work, and in research. Invitations have gone out to the full panel, but at the Commission's Washington headquarters it was said their names would not be announced officially until letters of acceptance have been received.

Dr. Martin, president-elect of the AMA, has been active in association work for many years. He is in private practice at Norfolk, Va.

Dr. Crosby, research director for the Task Force, is director of the Joint Committee on Accreditation of Hospitals, with headquarters in Chicago. The committee is supported by AMA and the American Association of Medical Colleges. Dr. Crosby is the immediate past president of the American Hospital Association. He expects to divide his time between the Task Force and the accreditation committee. Under commission procedure, Task Forces may hire their own staffs and set up headquarters in any city the members find convenient.

Chairman of the Medical Task Force will be Mr. Chauncey McCormick of Chicago, an associate of Mr. Hoover in European rehabilitation work following World War I. He has been active in organizations concerned with blindness, child care, and welfare problems.

HEALTH GRANTS TO CONTINUE, ROCKEFELLER TELLS HEALTH OFFICERS

THE AMA Washington Letter, No. 45

Undersecretary Nelson Rockefeller, addressing state and territorial health officers at their 52nd annual conference with federal health officials on November 5, declared: "Let me state categorically that grants to health activities will continue." The issue, he said, is how a given function "can best be performed and supported." The No. 2 official in the Department of Health, Education, and Welfare made these additional points: (1) in the poorest states with the greatest health needs, the nation as a whole has a responsibility, (2) the government should provide special aid to unique projects such as migratory labor groups, (3) technical and professional aid to states will be continued, and (4) the federal-state partnership should have the motto: "Maximum opportunity for state decision and minimum federal control."

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

At a recent meeting of the Allegany-Garrett County Medical Society, Dr. William K. Diehl, Professor of Gynecology at the University of Maryland discussed "Functional Uterine Bleeding." Dr. Diehl's talk was illustrated with lantern slides.

The Allegany County Health Department has announced the discontinuance of the night clinic.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

Journal Representative

The Committee on Emergency Medical Calls has met periodically. The system seems to be running quite smoothly. There is a need for additional

physicians to sign up. Any members of the Society who can see their way clear to help out, even for a month or so, should see the Chairman of the Committee, Dr. Paul E. Carliner, and arrange to be put on the rosters.

A TV closed circuit broadcast in November was much enjoyed by those who saw it. The length of the show aroused some discussion and it is probable that a second one, if it can be arranged, will be briefer.

Postgraduate courses will be underway and a copy of the program will be mailed to each member. Members of the Medical and Chirurgical Faculty are cordially invited and urged to attend these courses, regardless of whether membership is in the Baltimore City Medical Society or one of the County Societies. President Gundry intends to follow the schedule of courses as developed by the Committee and wants it understood that suggestions are always welcome.

The detailed program of the postgraduate courses is as follows:

DERMATOLOGY

All sessions will be held in the early afternoon.

Tuesday, January 5, 1954

University of Maryland School of Medicine
CHEMICAL HALL

12:00 noon Briefing session on all courses. H. M. Robinson, Jr., M.D.
University Hospital
OUT-PATIENT DEPARTMENT

12:10 p.m. Clinical Demonstration. H. M. Robinson, Sr., M.D., and Staff
University of Maryland School of Medicine
CHEMICAL HALL

1:00 p.m. Infant Eczema. H. M. Robinson, Sr., M.D.
1:15 p.m. Superficial Mycoses. Eugene S. Bereston, M.D.
1:30 p.m. Psoriasis. Israel Zeligman, M.D.
1:45 p.m. The Acne Problem. H. M. Robinson, Jr., M.D.
2:00 p.m. Simple Office Procedure for Demonstration of Fungi. Morris M. Cohen, M.D.

Tuesday, January 12, 1954

The Johns Hopkins Hospital
HURD HALL

2:00 p.m. Lecture Demonstration. Benign and Malignant Neoplasms of the Skin Lloyd W. Ketron, M.D., and Maurice Sullivan, M.D.

Tuesday, January 19, 1954

University Hospital OUT-PATIENT DEPARTMENT		
12:00 noon	Clinical Demonstration.	H. M. Robinson, Sr., M.D., and Staff
1:00 p.m.	Effect of Emotions on the Skin.	Mark Hollander, M.D.
1:15 p.m.	Contact Dermatitis.	Albert Shapiro, M.D.
1:30 p.m.	Occupational Dermatoses.	R. C. V. Robinson, M.D.
1:45 p.m.	Lupus Erythematosus.	William R. Bundick, M.D.
2:00 p.m.	Parasitic Diseases.	David Bacharach, M.D.

Tuesday, January 26, 1954

The Johns Hopkins Hospital HURD HALL		
2:00 p.m.	Review of General Principles of Topical Therapy of Dermatitis or Eczema.	H. Hanford Hopkins, M.D.
3:00 p.m.	Seborrheic Dermatitis.	Leon Ginsburg, M.D.

Tuesday, January 28, 1954

University Hospital OUT-PATIENT DEPARTMENT		
12:00 noon	Clinical Demonstration.	H. M. Robinson, Sr., M.D., and Staff
	University of Maryland School of Medicine CHEMICAL HALL	
1:00 p.m.	Panel Discussion. Members of Panel will answer questions proposed by attending physicians on diagnosis and treatment of dermatoses.	

HEMATOLOGY

NEW CLASS ROOM—THE JOHNS HOPKINS HOSPITAL

Wednesday Evenings, 7:30 to 9:30 p.m.

1954		
February 3	Diagnosis and Treatment of Anaemias.	C. Lockard Conley, M.D.
February 10	Leukemias and Lymphomas.	Milton S. Sacks, M.D., and Staff
February 17	Hemorrhagic Disorders.	Dudley P. Jackson, M.D.
February 24	Blood Groups, Immunology, including Erythroblastosis and Transfusion Problems.	Milton S. Sacks, M.D., and Staff

ENDOCRINOLOGY

HURD HALL—THE JOHNS HOPKINS HOSPITAL

Thursday Evenings, 8:30 p.m.

1954		
March 4	Disorders of the Pituitary Gonads.	H. F. Klinefelter, Jr., M.D.
March 11	Disorders of the Pancreas.	T. Nelson Carey, M.D.
March 18	Disorders of the Adrenals.	John Eager Howard, M.D.

Wednesday Evening, 8:30 p.m.

March 24	Disorders of the Thyroid.	Samuel P. Asper, Jr., M.D.
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DISTURBANCE OF WATER AND ELECTROLYTE METABOLISM

NEW CLASS ROOM—THE JOHNS HOPKINS HOSPITAL

Thursday Evenings, 8:00 p.m.

1954		
April 1	Some Physiological Background to Problems in Water and Electrolyte Metabolism.	J. L. Lilienthal, Jr., M.D.
April 8	Mechanisms and Treatment of Water and Electrolyte Disturbances in Medicine.	Kenneth L. Zierler, M.D.
April 15	Water and Electrolyte Disturbances in Pediatrics and in Diseases of the Nervous System.	Harold E. Harrison, M.D.
April 22	Water and Electrolyte Disturbances in Surgery.	Eric Nanson, M.D.

MONTGOMERY COUNTY MEDICAL SOCIETY

CHARLES I. WARFIELD, M.D.

Journal Representative

On December 15 at Woodmont Country Club, the Montgomery County Medical Society celebrated its 50th Anniversary with a dinner and dance. The highlight of the evening was an address by Governor McKeldin of Maryland. Also present were U.S. Senator Hyde and Congressman Beall of Maryland; and other honored guests.

Governor McKeldin and Dr. C. Warfield, Chairman of the Public Relations Committee of the County Society, appeared on the Mark Evans T. V. Show, previous to attending the affair at Woodmont. The event was carried in all metropolitan newspapers and by all local radio stations.

The Montgomery County Medical Bureau which is sponsored by the County Medical Society has just successfully completed its first year in operation. The Emergency Call System of the Montgomery County Medical Society and Medical Bureau has received wide spread national publicity, including an article in Medical Economics. Several State and County Societies have since adopted identical or similar programs.

WASHINGTON COUNTY MEDICAL SOCIETY

OMAR D. SPRECHER, JR., M.D.

Journal Representative

The third regular quarterly meeting of the Washington County Medical Society was held at the Alexander Hotel.

Thomas McPherson Brown, M.D. Prof. of Medicine, George Washington School of Medicine, Washington, D. C., was the principal speaker, on the subject "*A Concept of the Basic Mechanisms and Management of Rheumatic Diseases and Arthritis.*" This was a very interesting and well-presented discussion, based on his research and clinical experience over many years. The clinical results obtained have not been over a long enough period of time, as yet, for final evaluation.

Dr. John M. Welch (Col. U.S.A. (Ret.)) Chief of Medical Services, Maryland Civil Defense, gave a brief review of progress in organization, anticipated number of casualties in event of Atomic Attack, and pointed out the necessity for 100% Cooperation of the Medical profession in the organization. Dr. Ernest F. Poole, Chief of Medical Service, Washington County Civil Defense, was complimented on the structural organization, completed here to date.

Officers were elected for the coming year as follows:

President:—Archie R. Cohen

Vice-President:—S. Earl Young

Sect. & Treas.:—Ernest F. Poole

A textbook on Surgery was presented to the Washington County Hospital Staff Library in memory of the late Dr. Daniel A. Watkins, one of the early surgeons at the hospital, and Emeritus Member of the Washington County Medical Society.

DR. FRANK BERRY TO SUCCEED DR. CASBERG

The AMA Washington Letter, No. 45

Shortly after the first of the year Dr. Frank Brown Berry, a New York surgeon with military service in two World Wars, will succeed Dr. Melvin A. Casberg as Assistant Secretary of Defense for health and medical affairs. Dr. Berry, professor of clinical surgery at Columbia University Medical School, holds the rank of brigadier general, retired; in the last war he headed the 9th Evacuation Hospital in various parts of Europe. Dr. Berry will be the top ranking medical official in Defense Department, responsible for operation and coordination of Army, Navy, and Air Force medicine. Dr. Casberg is returning to private practice in Solvang, California.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

INFLUENZA

LOUIS KRAUSE, M.D.*

A scourge that has visited mankind over the ages, its origin and epidemiology for the most part is one of conjecture. History indicated its probable recurrence every several decades leaving a heavy toll in its wake. There is some reason to believe that it visited our own New England shores in 1617 and 1619, just a few years before the Pilgrims landed; and their records showed the frequency of Indian villages being wiped out and great numbers of

skeletons found in the woods with no evidence of death from trauma, suggesting again the possibility that an influenza epidemic had visited the place. It may be that this accounted for the lack of resistance offered the early settlers in landing in America. It is true that often, disease will foil armies and alter the events of history.

Many of us remember the epidemic of 1918; and the terrible death toll, particularly amongst the apparently very healthy young folks both in civil life and in the army at that time. In all likelihood, it will follow its cycle and perhaps recur again.

Appended is a list of books in the Library on old and recent knowledge on this threatening epidemic

* Chairman, Library Committee.

BOOKS ON INFLUENZA IN THE MEDICAL AND CHIRURGICAL FACULTY LIBRARY

Cinchona products institute, inc. Influenza and quinine. New York, Cinchona products institute, inc., 1938.

Crookshank, F. G., ed. Influenza. London, W. Heinemann, ltd., 1922.

Curtin, R. G. & Watson, E. W. Papers on the epidemic of influenza from 1889 to 1892. Philadelphia, n. p., 1892.

Dowse, T. S. On the brain and nerve exhaustion (neurasthenia) and on the nervous sequelae of influenza. 4th ed., London, Bailliere, Tindall and Cox, 1894.

Eade, Sir P. Medical notes and essays. Influenza. 2nd ed., London, Jarrold & Sons, 1896.

Great Britain. Local government board. Report on the influenza epidemic of 1889-90. London, H. M. Stationery Office, 1891.

Great Britain. Local government board. Further report and papers on epidemic influenza, 1889-92. London, H. M. Stationery Office, 1893.

Great Britain. National health insurance joint committee. Medical Research committee. Studies of influenza in hospitals of the British armies in France, 1918. Oxford, University Press, 1919.

Hoffman, F. L. Some statistics of influenza. New Jersey, Prudential Press, 1919.

Hopkirk, A. F. Influenza: its history, nature, cause and treatment. London, New York (etc.), The Walter Scott publishing company, ltd., 1914.

Johnson, R. An inaugural dissertation on the influenza. In Caldwell, Charles, ed., Medical theses, vol. 2, Philadelphia, Thomas & William Bradford, 1806.

Lereboullet, Pierre. La grippe: clinique, prophylaxie, traitement. Paris, Baillière, 1926.

Massini, R. Influenza, grippe. In Bergmann, G. von and Staehelin, R., eds. Handbuch der inneren medizin, vol. 1, pt. 1. Berlin, Julius Springer, 1925.

McCoy, G. W. Experiments upon volunteers to determine the cause and mode of spread of influenza, San Francisco, November and December, 1918. In U. S. Hygienic laboratory. Bulletin. Washington, Government printing office, 1921.

McIntosh, J. Studies in the aetiology of epidemic influenza. London, University Press, 1922.

Ministry of health. Report on the pandemic of influenza, 1918-1919. London, H. M. Stationery Office, n. d.

Opie, E. L. and others. Epidemic respiratory disease. St. Louis, Mosby, 1921.

Porter, H. H. Origin, symptoms and cure of the influenza. Philadelphia, Henry H. Porter, 1832. (Monographs, vol. 68)

Rosenau, M. J. Experiments upon volunteers to determine the cause and mode of spread of influenza, Boston, November and December, 1918. In U. S. Hygienic laboratory. Bulletin. Washington, Government printing office, 1921.

Rosenau, M. J., and others. Experiments upon volunteers to determine the cause and mode of spread of influenza, Boston, February and March, 1919. In U. S. Hygienic laboratory. Bulletin. Washington, Government Printing Office, 1921.

Rouvier, J. Identité de la dengue et de la grippe-influenza. Paris, Vve J. Lechevalier, 1890.

Stuart-Harris, C. H., and others. A study of epidemic influenza. London, H. M. Stationery Office, 1938.

Thompson, E. S. Influenza or epidemic catarrhal fever. London, Percival & Company, 1890.

Thompson, T. Annals of influenza or epidemic catarrhal fever in Great Britain. Sydenham Society Publishers, 1852.

U. S. Department of commerce. Bureau of the census. Special tables of mortality from influenza and pneumonia in Indiana, Kansas and Philadelphia, Pennsylvania, September 1 to December 31, 1918. Washington, Government Printing Office, 1920.

Vaughan, W. T. Influenza, an epidemiologic study. Baltimore, American Journal of Hygiene, 1921. (American Journal of Hygiene, Monographic series no. 1)

Winternitz, M. C. and others. The pathology of influenza. New Haven, Yale University Press, 1920.

Zuelzer, W. Erysipelas (rothlauf, rose, St. Anthony's fire.) *In* Handbuch der speciellen pathologie und therapie. vol. 2, pt. 2. Leipzig, F. C. W. Vogel, 1874.

Zuelzer, W. Influenza, Schweissfriesel, dengue-fieber, heufieber, erysipelas. *In* Handbuch der speciellen pathologie und therapie, vol. 2, pt. 2. Zweite auflage. Leipzig, F. C. W. Vogel, 1877.

FACULTY MEMBERS!

If the parking situation keeps you from using the library as much as you wish, remember you can park in the lot behind the Faculty Building until five o'clock. Entrance on Maryland Avenue.

A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

- * Conference on the nephrotic syndrome. 4th ed., n.p., n.d.
- Craig, C. F. & Faust, E. C. Clinical parasitology. Phila., Lea & Febiger, 1951.
- Glasser, O. and others. Physical foundations of radiology. N. Y., Hoeber, 1952.
- * Goldblatt, H. Renal origin of hypertension. Springfield, Thomas, 1948.
- * Lagerlof, H. O. H. Pancreatic function and pancreatic disease. N. Y., Macmillan, 1942.
- Lederer, F. L. Diseases of the ear, nose and throat. 6th ed., Phila., Davis, 1952.
- * Maryland State Planning Commission. Nursing needs & resources. Balto., Md. St. Plan. Comm., 1953.
- Rich, A. Pathogenesis of tuberculosis. Springfield, Thomas, 1951.
- * Salter, W. T. Chemical developments in thyroidology, Springfield, Thomas, 1950.
- Sheldon, J. M. Clinical allergy. Phila., Saunders, 1953.
- * Souttar, H. S. Physics and the surgeon. Springfield, Thomas, 1948.

* Indicates gifts.

- U. S. Department of Health, etc. Directory of state & territorial health authorities. Govt. Print. Off., 1953.
- Willis, R. A. Pathology of tumors. St. Louis, Mosby, 1953.
- Yearbook of general surgery. 1953-54 series. Chic., Yearbk., 1953.
- Yearbook of obstetrics and gynecology. Chic., Yearbk., 1953.

NEW SUBSCRIPTIONS

Subscriptions to the following periodicals have been entered, to begin with January 1954.

- ANNALS OF THE RHEUMATIC DISEASES
- BIOCHEMICAL JOURNAL
- BRITISH JOURNAL OF RADIOLGY
- CLINICAL PROCEEDINGS OF THE CHILDREN'S HOSPITAL, WASHINGTON, D. C.
- JOURNAL OF INVESTIGATIVE DERMATOLOGY
- JOURNAL OF THE AMERICAN GERIATRICS SOCIETY
- ORAL SURGERY, ORAL MEDICINE, AND ORAL PATHOLOGY
- THORAX

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, November 27-December 24, 1953

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MEINGOCOCCUS	MUMPS	POLIOMYELITIS, PARA- LYTIC	POLIOMYELITIS, NON PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP., SORE THROAT INCL. SCARLET FEVER	THYROID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS
Total, 4 weeks																			
Local areas																			
Baltimore County.....	65	—	3	1	13	—	33	4	1	—	12	—	—	3	10	1	4	r-3	4
Anne Arundel.....	2	—	—	3	—	1	3	1	—	—	—	—	—	25	8	—	2	—	5
Howard.....	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—	—
Harford.....	2	—	—	12	—	1	15	—	—	—	17	—	—	5	5	—	—	—	1
Carroll.....	2	—	—	2	1	—	—	1	1	—	1	—	—	4	—	1	—	—	4
Frederick.....	4	—	2	1	—	—	1	1	—	—	9	—	—	6	2	—	3	—	—
Washington.....	—	—	—	4	—	—	—	2	2	—	—	—	—	—	—	—	2	—	1
Allegany.....	1	—	—	9	—	—	1	1	—	—	2	—	—	2	—	—	—	—	3
Garrett.....	—	—	—	2	—	—	—	1	—	—	3	—	—	—	—	—	—	—	—
Montgomery.....	9	—	1	—	—	2	—	28	—	—	7	—	1	9	—	—	tu-2	—	—
Prince George's.....	6	—	—	2	—	—	5	1	—	—	11	—	—	2	9	—	6	—	4
Calvert.....	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
Charles.....	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Saint Mary's.....	—	—	—	2	—	—	—	1	—	—	1	—	—	—	—	—	4	—	2
Cecil.....	—	—	—	5	—	—	—	—	1	—	—	—	—	—	2	—	3	—	—
Kent.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—
Queen Anne's.....	—	—	—	—	—	—	6	1	—	—	—	—	—	—	—	—	—	—	—
Caroline.....	2	—	—	—	—	—	—	—	—	—	—	—	—	3	—	2	t-1	—	—
Talbot.....	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	e-1	—	—
Dorchester.....	—	1	—	—	—	1	—	1	—	—	—	—	—	—	1	—	10	tu-1	2
Wicomico.....	1	—	—	—	—	49	—	—	1	—	—	1	—	—	1	—	5	—	1
Worcester.....	1	—	1	3	5	—	3	—	—	—	—	—	—	—	1	1	—	—	1
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—
Total Counties.....	97	1	7	48	71	2	97	15	3	0	63	1	1	45	58	2	46	—	29
Baltimore City.....	192	0	5	8	194	2	176	1	0	0	38	0	0	57	108	5	424	t-1	24
State																			
Nov. 27-Dec. 24, 1953..	289	1	12	56	265	4	273	16	3	0	101	1	1	102	166	7	470	—	53
Same period 1952.....	278	12	1	27	24	1	65	5	0	0	85	3	0	31	173	16	595	—	51
5-year median.....	237	6	7	—	80	3	69	8	0	83	4	2	85	184	69	526	—	50	
Cumulative totals																			
State																			
Year 1953 to date.....	3188	12	1462	503	1973	77	2762	304*	216	25	2368	32	13	477	2259	150	7642	—	689
Same period 1952.....	3192	25	850	249	9151	80	1063	199	161	28	1033	23	15	225	2599	192	7440	—	630
5-year median.....	3437	74	542	—	4130	65	1723	226	—	56	1065	38	41	827	2672	852	7473	—	600

e = infectious encephalitis.

r = positive reports of rabies in animals.

t = tetanus.

tu = tularemia.

* = 13 cases of paralytic poliomyelitis have been removed from the records, not poliomyelitis, these cases were from Chestnut Lodge, Montgomery County, July 1953.



Blue Cross - Blue Shield



BLUE SHIELD HAS COME OF AGE

J. M. T. FINNEY, III*

The facts are clear. Better than words, they measure—for you and for us—the growth of Blue Shield. More than 1700 Maryland doctors, participants in Blue Shield, provide services for some 220,000 subscribers. And in 1953, the third year for the Maryland Medical Service, payments to doctors amounted to more than 1½ million dollars—for their services to 25,000 members.

The doctors themselves recognized the need for pre-payment: a program to help defray the cost of medical and surgical care. They wanted to do it in the "American Way." They wanted, primarily, to preserve the patient-doctor relationship, and, just as important, the patient's right to choose his own doctor. What they did not want was a political or governmental control which would accompany any compulsory system. The program had to be voluntary.

Their search for a voluntary system of prepaid medical and surgical care brought results in 1939 when the first non-profit plans under sponsorship of state medical societies and the A.M.A. were begun. Careful studies, conceived and directed by the Medical and Chirurgical Faculty with the help of local business men and specialists in insurance, produced a program—for Maryland—which, in 1951, united with other plans known, collectively, as Blue Shield. For this effort, you—Maryland's doctors—deserve a vote of thanks.

Your sponsorship and your participation testify to your faith in Blue Shield. Its growth demonstrates the public's desire for such a program and, significantly a faith in the doctors who sponsor it. But for Blue Shield to maintain its growth it must have the continued support of all physicians.

Its popularity depends very largely upon your endorsement.

For stability, it must rely upon your protection.

Its worth depends upon your execution of its principles.

The vast majority of Maryland's physicians recognize these facts. An analysis of experience in 1953 reveals that over 90% of the Blue Shield members hospitalized were treated by participating physicians. In accordance with their agreement with Blue Shield, these physicians accepted the Blue Shield benefit as payment in full for care to those members whose incomes were below the specified limits. It is significant to note that they also accepted the Blue Shield benefit as payment in full for more than half (50.3%) of those members whose incomes exceeded the limits. Altogether, the Blue Shield benefits were accepted as full payment in 70.3% of all cases reported by participating doctors; the payments made by Blue Shield amounted to 76.2% of total charges for all cases.

This support—your support—is the measure of Blue Shield popularity. No commercial insurance program can match it. It is this kind of support that makes Blue Shield an ever increasing part of *every* doctor's practice. And Blue Shield, in return for this support, helps the medical profession.

Blue Shield, nationally, has already played a major part in the political demise of compulsory health insurance. It has created a public awareness of the efforts of the profession to put its own house in order and by these efforts, to place the best in medical and surgical care within reach of all Americans. As its growing membership increases the doctor's percentage of collection, it likewise reduces the problem of dunning patients for unpaid bills. Blue Shield payments are prompt. They insure an income for the doctor, even in a period of recession. And unlike any commercial program, Blue Shield is controlled by the doctors themselves—in premise and in execution.

* Assistant to the Director, Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*



BROOKS

DR. MAURICE C. PINOFFS, President of the Medical and Chirurgical Faculty of the State of Maryland chats with MRS. JOHN G. BALL, President, and with MRS. A. E. GOLDSTEIN, President-elect, of the Woman's Auxiliary at the Semiannual Meeting held at the National Institutes of Health in Bethesda, Maryland

DOCTOR'S WIFE HAS HER OWN TEN COMMANDMENTS

(Taken from Illinois Medical Journal,
August, 1940.)

She must not know the meaning of the word "jealous."

She must never gossip.

She must run a cafeteria, serving meals at all hours for her husband.

She must be—like Caesar's wife—above reproach.

She must have self-reliance and self-control.

She must be able to think quickly and sanely in emergencies.

She must be a diplomat, see all, hear all, say a lot, yet say nothing.

She must learn to bear stoically and without complaint, disappointments in her personal plans.

She must be a good mother and father, because doctors are often too busy to discipline their own children.

She must be a good "doctor" because doctors never take time to doctor themselves.—Author Unknown, Wichita Medical Bulletin.

VOLUNTARY HEALTH INSURANCE SHOWS GAINS*

In all parts of the country, the American people voluntarily increased their protection against the unexpected costs of hospital, surgical and medical care to new heights in 1952—reports the Health Insurance Council in its current annual survey of accident and health coverage in the United States. The AMA's Council on Medical Service is distributing copies of the report to medical schools, teaching hospitals, and state and county medical societies.

Organizations contributing data to the Insurance Council's report include insurance companies, Blue Cross, Blue Shield and various other independent plans sponsored by business and industry, employee benefit associations and private group clinics.

Statistical highlights of the report: Nearly 92 million covered against *hospital expense*, an increase of more than $5\frac{1}{2}$ million over 1951; more than 73 million protected against *surgical expense*, an increase of more than $7\frac{1}{2}$ million; nearly 36 million carried *medical expense* coverage, an increase of 8 million; more than 38 million protected by *disability insurance*, a new high. In addition, nearly 700,000 persons had *catastrophic coverage*—the newest form of voluntary health protection designed to help meet the catastrophic costs of very serious illness.

Additional copies of the report are available on request from the Council on Medical Service.

CONFERENCE OF FEDERAL CIVIL DEFENSE ADMINISTRATION

NATIONAL WOMEN'S ADVISORY COMMITTEE

F.C.D.A., 1930 Columbia Road, N.W., Washington 25, D. C.

October 6th and 7th, 1953

Conference Roundtable on Emergency Care Services

Chairman: Dr. Mary H. S. Hayes,

Secretary: Mrs. George H. Yeager, Woman's Auxiliary to The American Medical Association.

Background: Dr. Robert H. Flinn explained to the roundtable group that medical plans for Civil

* Reprinted from News Notes—A.M.A., Vol. 2, No. 10.

Defense are based upon an expected five million casualties, in the event of atomic attack, two-thirds of which, or three million, three hundred thousand, will require hospital care.

Since the downtown hospitals of key cities will be knocked out, it is hoped that doctors and nurses can be flown in from surrounding territory. It would not be possible, though, to fly in the quantities of auxiliary nursing aides needed to care for the sick. The temporary two hundred bed hospitals set up around the city would each require fifteen doctors, probably including dentists and veterinarians, thirty-five professional nurses, one hundred auxiliary nurses, and seventy-five untrained auxiliary nurses.

Since professional medical personnel will have time only to direct the temporary two hundred bed hospitals, women's organizations are urged to see that their members, in both self-interest and public preparedness, take the following courses:

1. The Red Cross Home Nursing Course—which needs volunteers, both as students and trainers (teachers). Appropriate to organizations interested in health field.
2. The Red Cross First Aid Course. Appropriate to organizations working in health field.
3. The Emergency Feeding or Canteen Service, Red Cross or Salvation Army, etc. This seems especially appropriate for members of groups interested in home economics.

Volunteer support was asked also for:

1. The Blood Plasma Program of the Red Cross, or Private Blood Banks. (Expanders, while helpful, will not replace the need for plasma and whole blood).
2. The Block Warden Program of Civil Defense. The Warden as block chairman of neighborhood group must deal with welfare, fire, rescue, policing, care of children and invalids, communal feeding, sanitation, and be a sort of "Paul Revere."
3. The encouragement by women of participation by their husbands and families in the Civil Defense Program (with peacetime as well as war benefits).
4. The use of the Home Defense Action Plan of Civil Defense. A kit on Home Defense Action covers welfare, supply, emergency mass feeding, action outline, TV spot explanations, home shelters, and warden handbooks.

CIVIL DEFENSE

REPORT ON FEDERAL CIVIL DEFENSE ADMINISTRATION'S

NATIONAL WOMEN'S ADVISORY COMMITTEE

October 6th and 7th, 1953—Olney, Maryland

To: Mrs. Leo J. Schaefer, President, Woman's Auxiliary to the American Medical Association.

By: Mrs. George H. Yeager, serving as Alternate.

Report

Now that Russia has the atomic bomb and the TU4 type bomber to transport it, the threat of the use of the bomb by the United States is no longer a key to Civil Defense, nor is the question of Russia's possession of the hydrogen bomb important. Each American city must now plan that Russia has sufficient power to wipe out with one bomb, all its hospitals, with its doctors and nurses, its industry with its skilled labor, and its transportation system. The loss of industry in major cities will affect the interdependent manufacture in smaller communities. The key strength of our cities must be the support of the surrounding territory. Planes attacking American cities by flying across Alaska and Canada will have enough gasoline, after hitting their targets, to fly on to South America for the internment of the pilots. The cities so attacked would be "killed"—gone at least for a year or years.

Early warning of an imminent attack is vital to our cities. There is now no warning possible, especially to peripheral or border cities. We must get two hours warning to the cities on our peripheries. Then we can thin out heavily populated areas. Like a fire drill, a temporary withdrawal would reduce casualties by perhaps 80 per cent. We know that the use of ten atomic weapons could put out our entire railroad system. Therefore, we must plan to rebuild them if we are to continue to wage a war.

It is vital that we have a population educated in Civil Defense, or self preservation. Since the great majority of Civil Defense workers must be women, women's organizations must start practical programs of basic Civil Defense training for their members—not lectures, but to learn by doing. We must train people in home nursing as nurses' aides, as wardens,

and in rescue work. Wardens will train new wardens; nurses' aides, new aides; etc. Instead of a talk, get help from the police or the fire department and demonstrate at your meetings the use of rope and an ordinary step-ladder in rescue work. Anybody can do this, and you can be useful to the depleted rescue team if it arrives, during a bombing, or help your own out of the rubble. Film strips sent to National Women's Organizations will guide them as to what fire and police departments can teach them in self help.

Since pamphlets are no good unless applied, it is important to have our schools and colleges include Civil Defense as part of their regular curriculum. Civil Defense is now part of American life and each citizen's responsibility. With small children it is important to practice dead-pan, unemotional duck-and-cover drill, to have them wear identification bracelets, and to show them Civil Defense films, and to teach responsibility with faith in the future and life itself. Morale is always as important as shelter and we must fight neutralism, defeatism, despair, and the fact that people accept the bomb intellectually, but turn away, emotionally. Credit courses for Civil Defense in colleges and the mobilization of teaching facilities by twelve state governors are trends in the right direction.

Women's organizations should put on a practical action course that is simple, but will bring big results. Let us convince our members that after taking a few hours' training they can stand by, prepared rather than helpless in an emergency, whether it be peacetime or war. The Auxiliary to The American Legion has already sent leaders to the Olney, Maryland, Civil Defense Training Center, for a full week's course in Civil Defense. One great job that women will have will be to spike rumors. The enemy will use psychological warfare to twist our own warning system, our radio announcements, and may drop leaflets purporting to be from our own Government. The people who survive must be educated to the possibilities of psychological warfare.

We have in existence today an intricate national warning system and in our warehouses there are sixty millions of dollars worth of medical supplies. Our greatest and crucial defense against Russia, however, must be spiritual. This country was founded on Christian religious principles, including

the Ten Commandments, and Jesus gave as the most important of these, the first—"Thou shalt love the Lord thy God with all thy heart, and with all thy soul, and with all thy mind, and thy neighbor as thyself." Our spiritual strength will rest on this foundation.

Any comprehension of the magnitude and scope of the problem of atomic attack brings us, indeed, to our knees before God. We must have faith and show it by actually training ourselves for the days when each home may be a hospital—as home

nurses, nurses' aides, block wardens (at least in the daytime hours), as emergency cooks who can use salvage equipment, as trainees in sanitation problems, in registration and information services, and by convincing people that home and mass shelters are necessary.

The "know-how" of these things is provided in a kit called the *Home Defense Action Program*, and when people understand from a candid government what confronts them, they will want Home Defense Action.

Ancillary News



PHARMACY SECTION

NARCOTICS

L. M. KANTNER, PHAR.D.*

This article is prompted because of a telephone message recently received from an irate pharmacist. His anger was caused by what is substantially related here (profanity deleted).

"A physician just called me to take a prescription by phone, which among other ingredients contained morphine sulfate. When I advised the physician accepting verbal prescriptions for narcotics was in violation of the Narcotic Act he replied, 'I will call another drug store,' and hung up the telephone receiver without giving his name. I want to know what I can do about such a matter." Naturally the only answer that could be given there was nothing that could be done except for him to control his fit of anger.

As this is a complaint that is frequently made by pharmacists, it does not seem amiss from time to time to call attention to certain regulations pertaining to the prescribing and dispensing of narcotics, and the responsibilities that both the prescriber and dispenser must assume in dealing with these drugs.

Under Chapter 8, Art. 172, Narcotic Regulations, telephone orders are very definitely dealt with as follows:—The furnishing of narcotics pursuant to telephone advice of practitioners is prohibited, whether prescriptions covering such orders are subsequently received or not, except that in an emergency a druggist may deliver narcotics through his employee or responsible agent pursuant to a telephone order, *provided* the employee or agent is supplied with a properly prepared prescription before delivery is made.

Prescriptions for narcotics cannot be refilled under any circumstances, a new prescription must be fur-

nished when narcotic medication is to be continued. In conversation with a physician a short time ago it developed he had confused the Harrison Narcotic Act with the Durham-Humphrey Act. He was under the impression the Durham-Humphrey Act applied to all types of drugs including narcotics, which of course it does not—the provisions of the Durham-Humphrey Act come under the supervision of the Food and Drug Administration, Department of Health, Education & Welfare, while the Narcotic Act comes under the Bureau of Narcotics, Treasury Department. Virtually all physicians are meticulous when it comes to administering and prescribing narcotics, because they fully appreciate the danger and ease that a patient can develop addiction.

The error they sometimes make in prescribing narcotics is largely due to thoughtlessness. For instance prescriptions for narcotics cannot legally be written with pencil—they must be written with ink or indelible pencil or typewritten and in the latter case they must be signed with ink or indelible pencil—by the prescriber, a secretary cannot sign a narcotic prescription. If a pharmacist accepts a narcotic prescription by phone and dispenses it, naturally it is he who is the violator. No responsible physician would deliberately provoke a condition that would cause another to become involved in a law violation particularly one involving narcotics. However, this is exactly what happens when a physician requests a pharmacist to accept a prescription for narcotics by phone and it is dispensed, notwithstanding a signed prescription is promised to be supplied later.

Certainly a pharmacist can refuse to accept a narcotic prescription that a physician wishes him to take by telephone as in the case of the pharmacist who provoked this article. However if a pharmacist refuses to comply with such a request an unpleasant relationship is likely to result, which all

* Secretary, Maryland Board of Pharmacy.

well thinking pharmacists endeavor to prevent. Again it is recommended that physicians include on prescriptions (except those for narcotics) to refill a definite number of times *or* not to refill (N. R.)

This will save physicians the annoyance of pharmacists calling for authorization to refill a prescription that contains a drug that cannot be dispensed except on a prescription.

15-MAN HOOVER MEDICAL TASK FORCE COMPLETED: HAS 13 M.D.'S

The AMA Washington Letter, No. 46

The announcement of 12 more appointments completes the membership of the Hoover Commission task force on medical services. Earlier the commission named Mr. Chauncey McCormick, Chicago businessman, as chairman, and Dr. Edwin I. Crosby, also of Chicago, as research director. The third appointment announced earlier was that of Dr. Walter Martin, president-elect of the American Medical Association.

The following have accepted appointment to the remaining posts: *Dr. Francis J. Braceland*, dean, Loyola (Chicago) University School of Medicine, naval reserve captain, member Armed Forces Medical Advisory Committee; *Dr. Edward Delos Churchill*, chief of general surgical service, Massachusetts General Hospital, medical veteran both World Wars, member medical task force of first Hoover Commission; *Dr. Michael DeBakey*, professor of surgery and chairman of department of surgery, Baylor University College of Medicine, Army medical officer in World War II, member medical task force of first Hoover Commission; *Dr. Everts A. Graham*, surgeon-in-chief, Barnes Hospital and St. Louis Children's Hospital, medical veteran of World War I; *Dr. Alan Gregg*, vice president of Rockefeller Foundation, medical veteran of World War I, member Health Resources Advisory Committee, ODM; *Dr. Paul R. Hawley*, retired regular Army major general, director American College of Surgeons, former chief medical director, Veterans Administration; *Dr. Theodore George Klumpp*, president, Winthrop-Stearns, Inc., N. Y., and Winthrop Products, Inc., N. J.; *Dr. Hugh Rodman Leavall*, professor of public health practice, Harvard School of Public Health, member medical task force of first Hoover Commission; *Dr. Basil C. MacLean*, director, Strong Memorial Hospital and professor of hospital administration at University of Rochester, Army medical officer in World War II, consultant to medical task force of first Hoover Commission; *Dr. James Roscoe Miller*, president of Northwestern University, Army and Navy service in World War II; *Dr. Milton C. Winternitz*, chairman, division of medical sciences of National Research Council, Army medical officer in World War I; *Dr. Otto W. Brandhorst*, dean of Washington University (St. Louis) School of Dentistry.

Book Reviews*

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them.

Sex After Forty. S. A. Lewin, M.D., and John Gilmore, Ph.D. First printing, April, 1952, Medical Research Press, New York. Distributed by Grosset and Dunlap. Introduction, Rev. Dr. Russell L. Dicks, Duke University. 188 pages, plus glossary and index. Illustrated. \$3.50.

This book is widely received. It is already in its second printing. It is a very dignified and authoritative exposition of the subject. It has in it highly instructive and educational material. The chapter on endocrine glands is especially instructive and clear. In it is a compilation of authoritative views of the clergies on debatable subjects, all set down in simple and clear language. This book should have wide circulation, especially among the lay people.

W. H. T.

Textbook of Gynecology. Emil Novak, A.B., M.D., D.Sc. (Hon.), F.A.C.S., F.R.C.O.G. (Hon.), Assistant Professor Emeritus of Gynecology, The Johns Hopkins Medical School; Gynecologist-in-chief, Bon Secours and St. Agnes Hospitals, Baltimore; and Past President, American Gynecological Society; and Edmund R. Novak, A.B., M.D., F.A.C.S., Instructor in Gynecology, The Johns Hopkins Medical School; Gynecologist, Johns Hopkins, Bon Secours, St. Agnes and Union Memorial Hospitals, Baltimore. Fourth edition, 1952, The Williams and Wilkins Company, Baltimore. 781 pages plus index. Illustrated. \$9.00.

Dr. Novak states in an earlier preface, "The purpose of this book is to present as much information on gynecology as possible in a simple and practical fashion." He and his son have done this very well in this fourth edition. The material has been brought up to date in many chapters. A very timely and interesting discussion has been given to intraepithelial carcinoma. Other noted additions are the basal temperature chart in reference to ovulation, and Dr. Everett's revision of the section on female urology which includes the addition of the judicious use of antibiotics in urinary tract infections.

I highly recommend this text to medical students, general practitioners, and the gynecologists and obstetricians.

T. K.

* The reviews here published have been prepared by competent authorities and do not represent the opinions of any official bodies unless specifically stated.

The Literature on Streptomycin. Selman A. Waksman. Second edition, 1952, Rutgers University Press, New Brunswick, New Jersey. 553 pages. \$5.00.

This book is a non-annotated bibliography on streptomycin. Five thousand, five hundred and fifty (5,550) references are listed without regard to any sequential format. However, author and subject indices are provided. This book should prove useful to the libraries of antibiotic research laboratories and to large medical institutions as an ancillary reference aid only.

M. J. S.

The Low Fat Diet Cook Book. Dorothy Myers Hildreth, Dietitian, and Eugene A. Hildreth, M.D. Introduction by Francis C. Wood, M.D. Copyright 1952, Medical Research Press, New York. Distributed by Grosset and Dunlap. 131 pages plus index. \$2.95.

"The Low Fat Diet Cook Book" (Hildreth and Hildreth) presents basic facts upon which diets can be prepared to meet the requirements of individual cases. Menus can be planned if one follows diligently the fat restrictions noted, servings allowed and substitutions suggested. Mrs. Hildreth's menus for an entire week offer attractive and palatable meals, easily prepared from her recipes.

The supplementary recipes include many highly seasoned ones. Natural flavors are hidden instead of being enjoyed for themselves. These recipes, if followed too literally week after week, might cause metabolic disorders or intensify the circulatory ailments of advancing age which the physician is striving to lessen. Many of them read like good eating for the family and, occasionally, for the patient.

Special diets require close cooperation between the physician or dietitian, the one handling the diet and the patient. The effectiveness of any diet is measured by the achievements of the person administering same and the ability of the patient's body to use the foods offered. Naturally best results are obtained when the diet is administered by one having some general knowledge of foods and nutrition. However, simple directions can be followed and, if one is willing, much knowledge can be gained.

This book, and all other diet books, should supply basic information on the proper selection of foods, steps in preparation of same and modern methods of cooking.

Simple explanations of digestion, absorption and assimilations should be given. Charts furnishing the average chemical compositions, vitamin and mineral contents of foods, especially fruits and vegetables, their digestibility and caloric values should be included.

Given some instruction and having an eagerness to learn and achieve, one can then plan menus using those foods which supply the greatest curative, nutritional and protective elements. Both the patient and the family can be fed well and wisely.

R. A. R.

Monograph on Chlorophyll in Medicine. Published by Rystan Company Inc., Mount Vernon, New York. Copyright 1952. 53 pages. Illustrated.

This booklet may prove interesting, and may be secured without cost by writing to the Rystan Company, Inc., Mount Vernon, New York. Chloresium, which is featured in this booklet, is an A.M.A. Council accepted product.

A. J. J.

NO DOCTOR DRAFT NEEDED AFTER 1955, U. S. OFFICIALS AGREE

The AMA Washington Letter, No. 46

Present Defense Department planning envisions no extension of the doctor draft beyond July 1, 1955, but instead it calls for a program of "fence mending" and "belt tightening," federal officials concerned with the law stated at the annual meeting of the Association of Military Surgeons. This position was outlined at the same time that *Dr. Edward J. McCormick*, president of the American Medical Association, told the surgeons: "It is our belief that this is a most propitious time for devising a program which will clearly eliminate any need for this legislation well in advance of July 1, 1955."

Dr. Melvin A. Casberg, Assistant Secretary of Defense (Health and Medical), said steps taken or planned to stimulate regular medical officer procurement include study of a law to provide medical scholarships to students commissioned in the armed forces following graduation. He said, however, that this will create a problem: "All Indians and no chiefs." It is the duty of civilian organizations, he said, to aid the military in procuring more experienced doctors for teaching and training posts in the services.

Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, recommended a further reduction in the physician-troop ratio, from a projected 3.2 to 2.9, as one form of belt tightening. If the size of the armed forces doesn't increase, he believes it should be possible to meet requirements after mid-1955 from each year's graduating classes. In the meantime, however, drafting of doctors will resume late next summer or early fall, he said, with possibility that as many as 1,250 Priority III doctors in their early 30s will have to be called during the life of the act.

Dr. McCormick also made these points: (1) the problem of medical care for military dependents should be turned over for study to the Hoover Commission on government reorganization, with final determinations by Congress, (2) meanwhile there should be improved utilization of military medical personnel and curtailment in non-professional duties, (3) in the event a universal military training program is voted, then pre-professional and professional education for qualified students should be continued.

Letter to the Editor

October 30, 1953

Dr. George H. Yeager, Editor*
Maryland Medical Journal
1211 Cathedral St.
Baltimore, Md.

Dear Dr. Yeager:

Just to set the record straight, some comments seem necessary regarding a report on the function of the "County Medical Care Program" written by Dr. R. H. Riley, Director of the State Health Department. This article describes the action taken by the Health Department against seven physicians in the counties as "the functioning of the Medical Care Program" and totally ignores the wonderful work of almost one thousand hard-working conscientious physicians. Many of these doctors who participate in the county Medical Care Program do not make any charge at all to the State for their services to the poor and all of them have expressed their willingness to continue to treat indigent patients irrespective of the fee. A description of the Baltimore County Medical Care Program has been published in the Directory of same and is as follows:

"For a number of years, all over the United States, it has been realized that, in spite of the high quality of medical care available to our citizens, defects exist in the system. In the public mind the two most glaring defects seem to be that a few people do not have the money to pay for this medical care, and that a larger number suffer great financial distress in cases where illness is long drawn out, especially where the breadwinner of the family is affected.

Until very recently it was taken for granted that these problems were to be met by physicians rendering free service to the indigent, and by private charities taking care of the other financial needs of these unfortunates. However, many people are now beginning to feel that it is the responsibility of a government to take care of all its citizens, and that

* Article read before the Baltimore County Medical Association at the meeting just prior to November 6, 1953, and it was voted unanimously to have it published in the Maryland State Medical Journal.

it is therefore up to our government to see that everyone gets adequate medical care, and is protected from financial hardship during illness.

Regardless of the correctness of this political philosophy, it has become obvious to our national leaders that public opinion demands that something be done. Under this pressure various schemes have been proposed, schemes which have ranged all the way from attempts to have the national government take complete responsibility for all medical care ("socialized medicine"), to the development of voluntary insurance systems such as the Blue Cross.

In Maryland a method has been developed whereby the state accepts responsibility for medical care of its most needy citizens, but without falling into the trap of governmental interference with medical practice. Under it the state supplies the funds, each county administers the service according to the peculiar needs of the locality, and each patient has complete freedom in selecting his own physician.

For the benefit of those interested, a summary of the details of this system, as it currently works in Baltimore County follows:

The County Medical Care Program was founded in 1945, on the basis of a request from the Medical and Chirurgical Faculty made in 1939. The interim period was taken up by a detailed study of the medical needs and facilities for low-income families in the counties of Maryland. The recommendations of the study group were unanimously approved by the Faculty in 1944 and became the law of the State in 1945.

The program is founded on the following basic principles, some explicit and others implicit in the law and the regulations:

(1) The program is State-financed, with no Federal aid or intervention.

(2) It is based on the prevailing method of medical practice in the counties, namely, a fee-for-service system in which the general practitioner is the key figure.

(3) It is administered by the State Department of Health.

(4) It is designed to take care of the medical needs (exclusive of hospitalization which is under a different program) of those on relief and a group of so-called medically indigent, who are normally self-supporting but cannot afford the cost of illness.

(5) It is dedicated to the maximum possible amount of professional freedom and the minimum amount of regulations consistent with efficient, economical administration.

(6) It is dedicated to the free choice of physician (and other professional personnel) by the patient, as well as to the professional participant's right to accept or refuse patients as he desires.

The program provides the following services:

(1) Physician's Service in the home, office, and nursing home. Delivery in the home or hospital. Consultant services may be made available.

(2) Drugs as prescribed or dispensed by the physician, with very few limitations in the way of experimental drugs.

(3) Dental Services, including fillings, extractions, X-ray, fluoride therapy, and dentures on a limited basis.

(4) Special Diagnostic Services, beyond the scope of the physician's office, in hospital, outpatient departments.

Who is Eligible?

(1) All recipients of public assistance are automatically eligible.

(2) Any person who believes himself to be unable to pay for medical care may apply to the Health Department in the county of his residence. Eligible

bility is determined on the basis of objective standards of income and resources, and in exceptional cases, on the health officer's judgment concerning medical and social needs. Eligible patients are identified by special cards issued by the Health Department.

How may a Physician Participate?

Any licensed physician may participate automatically by submitting bills for any eligible patient. One bill is submitted for each patient seen during a given month. Payment is promptly made by the end of the month, following the month during which services were rendered. Bill forms and detailed instructions may be obtained from the County Health Department in the county of the physician's residence."

This program has proven eminently successful to both doctor and patient and has the cooperation of 95% of the physicians. This is direct contrast to the panel system in Baltimore City where physician participation is small and patient does not have free choice of doctor or hospital.

Leaders in medicine throughout our country have called Maryland's County Medical Care Program the answer to threats of socialized medicine in the care of the indigent patient.

Yours very truly,
Charles H. Williams, M.D.,
Chairman
Board of Governors
Baltimore County Medical
Association, Inc.

HEALTH OFFICERS OPPOSE CUTS IN FEDERAL GRANTS

The AMA Washington Letter, No. 46

The Association of State and Territorial Health Officers opposes further cuts in federal grants-in-aid for health programs pending action of the Commission on Intergovernmental Relations (Manion Commission), which is studying the whole field of federal-state relationships. The association also urges that once Congress implements any commission proposals it give the states time to make budgetary adjustments, because some legislatures meet only every two years. The association took these stands at its annual meeting in Washington with federal health officials. It also (a) recommended that more funds be spent for civil defense at both federal and state levels, (b) urged passage of legislation transferring Indian hospitals to PHS, with the consent of the Indians, (c) recommended that AMA and other groups cooperate in a campaign for routine chest examinations of all hospital admissions and periodic x-rays of staffs, (d) recommended that necessary steps be taken to assure that the 1954 supply of gamma globulin will be adequate for reasonable foreseeable needs.

COMING MEETINGS

SYMPOSIUM ON THE MEDICAL AND LEGAL ASPECTS OF MALPRACTICE

Osler Hall, 1211 Cathedral Street

Thursday, February 4, 1954, 8:00 p.m.

Moderator—The Honorable Lansdale G. Sasscer

Participants to be announced later.

These programs are arranged under the auspices of the Subcommittee on Symposia Management of the Joint Medicolegal Committee of the Bar Associations and the Medical and Chirurgical Faculty.

This is a vital subject and all the members of the Medical and Chirurgical Faculty are urged to arrange their schedules so that they can be present.

POSTGRADUATE COURSES

Presented by the Baltimore City Medical Society, its Sections, and the Maryland Academy of General Practice.

HEMATOLOGY

New Class Room—The Johns Hopkins Hospital

Wednesday Evenings, 7:30 to 9:30 p.m.

February 3, 1954 Diagnosis and Treatment of Anæmias.

C. Lockard Conley, M.D.

February 10, 1954 Leukemias and Lymphomas.

Milton S. Sacks, M.D., and Staff

February 17, 1954 Hemorrhagic Disorders.

Dudley P. Jackson, M.D.

February 24, 1954 Blood Groups, Immunology, including

Milton S. Sacks, M.D., and Staff

Erythroblastosis and Transfusion Problems

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Mrs. Thomas C. Webster, *President*

Mrs. Conrad Acton, *Secretary*

Mrs. Whitmer B. Firor, *Treasurer*

Wednesday, February 3, 1954, 11:00 a.m., Osler Hall

Dr. Murray C. Brown, Chief of Clinical and Professional Education at the Clinical Center of the National Institutes of Health, Bethesda, Maryland, will speak on the program and facilities of the National Institutes of Health. (Illustrated.)

Collation

NEUROPSYCHIATRIC SECTION

Leonard J. Gallant, M.D., *Secretary*

Thursday, February 11, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street

Dynamic Considerations in the Treatment of Schizophrenia. Lewis B. Hill, M.D., Psychiatrist-in-Chief, Sheppard and Enoch Pratt Hospital.

Discussants:

John C. Whitehorn, M.D., Professor of Psychiatry, The Johns Hopkins University School of Medicine.

Sarah S. Tower, M.D., Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine.

RADIOLOGICAL SECTION

David N. Gould, M.D., *Chairman*

H. Leonard Warres, M.D., *Secretary*

JOINT MEETING WITH THE OBSTETRICAL AND GYNECOLOGICAL SOCIETY OF MARYLAND

Tuesday, February 16, 1954, Sheraton Belvedere Hotel

Film-reading Session, 5:30 p.m.

Cocktails 6:30 p.m. Dinner 7:30 p.m.

Scientific Session, 8:30 p.m.

Radiation Therapy of Carcinoma of the Cervix. Isadore Lampe, M.D., Professor Roentgenology, University of Michigan, Ann Arbor, Michigan.

ALL WHO ARE INTERESTED ARE INVITED TO ATTEND THE FILM READING SESSION AND THE FORMAL LECTURE.

ANESTHESIA STUDY COMMITTEE

Wednesday, February 17, 1954, 8:30 p.m.

Faculty Building, 1211 Cathedral Street

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

Richard W. TeLinde, M.D., *Chairman*

Beverley C. Compton, M.D., *Secretary*

Thursday, February 18, 1954, 5:00 to 6:00 p.m.

1211 Cathedral Street, Lower Floor

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall, 1211 Cathedral Street

Friday, February 19, 1954, 8:30 p.m.

8:45 p.m.

Hypothermia. Kenneth K. Keown, M.D., Associate Professor of Anesthesiology, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania. (Illustrated.) (By invitation.)

9:30 p.m.

Hypotensive Anesthesia. Hrant H. Stone, M.D., Director, Department of Anesthesiology, Graduate Hospital, University of Pennsylvania; Assistant Professor of Anesthesiology, Graduate School of Medicine, University of Pennsylvania; Associate Professor of Anesthesiology, Woman's Medical College of Pennsylvania, Philadelphia, Pennsylvania. (By invitation.)

10:15 p.m.

Question Period

MATERNAL MORTALITY COMMITTEE

Thursday, February 25, 1954, 4:00 p.m.

Faculty Building, 1211 Cathedral Street, Baltimore

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

**THE SOUTHEASTERN SURGICAL CONGRESS
BIRMINGHAM ASSEMBLY**

Twenty-Second Annual Meeting

MARCH 8, 9, 10, 11, 1954

SPEAKERS

Jack Greenfield, M.D., Memphis, Tenn.

A Diagnostic Survey for Extragastrintestinal Left Upper Quadrant Lesions

William G. Hamm, M.D., Atlanta, Ga.

Elephantiasis of the Lower Extremities

John K. Webb, M.D., Greenville, S. C.

Adrenalectomy in Recurrent Breast Carcinoma

Waltman Walters, M.D., (Guest), Rochester, Minn.

Obstructive Jaundice, Its Diagnosis and Treatment

Michael E. De Bakey, M.D., (Guest), Houston, Texas

Surgical Considerations of Aortic Aneurysms

Kenneth W. Warren, M.D., (Guest), Boston, Mass.

Current Management of Benign and Malignant Pancreatic Tumors

Francis A. Marzoni, M.D., Birmingham, Ala.

The Management of Maxillo-Facial Injuries

George W. Holmes, M.D., Winston Salem, N. C.

The Management of Some Problem Fractures in Children

Leslie V. Rush, M.D., Meridian, Miss.

Three Point Pressure in Fractures Near Joints

M. M. Zinninger, M.D., (Guest), Cincinnati, Ohio

Spread of Cancer of the Stomach Through the Intramural Lymphatics and its Relation to Gastrectomy

Harris B. Shumacker, Jr., M.D., (Guest), Indianapolis, Ind.

The Surgical Treatment of Chronic Constrictive Pericarditis

Raymond W. McNealy, M.D., (Guest), Chicago, Ill.

Pharyngo-Esophageal Diverticula

MARK THESE DATES ON YOUR
CALENDAR NOW AND PLAN TO ATTEND

The Annual Meeting
of the Medical and Chirurgical Faculty



TUESDAY, APRIL 27, 1954 and WEDNESDAY, APRIL 28, 1954

Business Meetings, MONDAY, APRIL 26, 1954

Faculty Ball, MONDAY EVENING, APRIL 26, 1954

MORE LIBERAL TAX DEDUCTIONS PROPOSED FOR MEDICAL CARE COSTS

The AMA Washington Letter, No. 45

When Congress reconvenes in January it may be asked to liberalize federal income tax deductions for medical expenses. This is one of the suggestions expected to be made by the staff of the House Ways and Means Committee, which has been working on tax amendments since last summer.

Under present law adjusted, taxpayers may deduct only that part of medical expenses in excess of 5% of gross income. The committee staff is considering proposing that this be changed to 3%. It is estimated that the government would lose \$150 million in revenue annually if this restriction is eased.

Another modification under discussion would eliminate the maximum limitation on medical expense deductions. Now it is \$1,250 per year for a single person, \$2,500 for one with one dependent, \$3,750 for a married couple with one dependent, and \$5,000 for a married couple with two or more dependents. It is pointed out that so few persons contract medical care bills of such size that the revenue loss to the government would be negligible. The committee staff also contemplates recommending raising the \$600 earnings limitation on dependents who are students. The suggestion is to lift this ceiling in the case of students, so parents can continue to claim them as dependents even if their earnings exceed the \$600.

AMERICAN GERIATRICS SOCIETY NOTICE

The American Geriatrics Society announces that effective with January, 1953, they will publish their own official periodical to be called "THE JOURNAL OF THE AMERICAN GERIATRICS SOCIETY." Dr. Willard Thompson, of Chicago, is President of the Society and will edit the journal. Dr. Malford Thewlis of Wakefield, R. I., is Permanent Secretary. All physicians interested in diseases of the aging are invited to join the society. The new journal will be published for the Society by the Williams & Wilkins Company, of Baltimore, Maryland.

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HISTOCHEMICAL SOCIETY NOTICE

The Histochemical Society announces that effective in January, 1953, they will begin publications of a bi-monthly periodical to be known as the "Journal of Histochemistry and Cytological Chemistry." The journal will be published by The Williams & Wilkins Company of Baltimore, Maryland; it will appear every other month beginning January, and the subscription price will be \$7.50. It will be edited by Dr. R. D. Lillie, of the National Institutes of Health, Bethesda, Maryland.



DOCTOR, TAKE THIS HOME TO YOUR WIFE!

Be a member; participate in our program of health education and of support for American principles, fighting Socialized medicine.

Application for Active or Associate Membership

**in the Woman's Auxiliary
to the Medical and Chirurgical Faculty of the State of Maryland
THROUGH THE
WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY
1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND**

1. NAME.....
2. ADDRESS.....
3. SPONSORING PHYSICIAN.....
4. CHECK TYPE of MEMBERSHIP

Active	<input type="checkbox"/>
Associate	<input type="checkbox"/>
5. DATE.....

Application must be accompanied by membership fee.

Active Dues \$5.00 (wives of doctors who are members*)

Associate Dues \$3.00 (mothers and sisters of doctors who are members or wives of associate members)

* Members of the Baltimore City Medical Society and the Medical and Chirurgical Faculty.

